

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08672

FOR STATE
HEALTH DEPT.TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A. CO.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>X Mayo</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. Anne Arundel Gen.</i>		e. STREET ADDRESS <i>X Mayo</i>	
3. NAME OF DECEDENT (Type or print) <i>Calvin Alexander</i>		First <i>Calvin</i>	Middle <i>Alexander</i>
4. DATE OF DEATH <i>Aug 30 1960</i>		Month <i>Aug</i>	Day <i>30</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4-23-1918</i>		9. AGE (In years last birthday) <i>42</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country) <i>Washington D.C. U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-16-8268</i>	17. INFORMANT <i>Virginia Alexander Mayo Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <i>Due to</i>		Address <i>Huller</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John K. Hall</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>8/31/68</i>
EXAMINER'S NAME (Type) <i>E. Fincheroff</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 9-4-60</i>	22b. DATE THEREOF <i>9-4-60</i>	22c. NAME OF CEMETERY OR CEMATORIY <i>St. Marks</i>
22d. LOCATION (City, town, or county) <i>X Mayo, md.</i>	22e. (State) <i>X</i>	24a. REC'D BY REGISTRAR DATE SEP 1 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		ADDRESS	

Mr. Smith - Smith's
Mr. Smith - Smith's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8693

CERTIFICATE OF DEATH

Reg. Dist. No.

08673

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Md.		e. STREET ADDRESS 711 Melrose St.		d. STREET ADDRESS 711 Melrose St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Margaret	Middle Elizabeth	Last ALLSTON	4. DATE OF DEATH August 14th 1960	Month August	Day 14	Year 1960
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S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-09	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Louis FISHER	14. MOTHER'S MAIDEN NAME Mary E. PARKINSON	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Husband 711 Melrose St., Annapolis, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction	INTERVAL BETWEEN ONSET AND DEATH 20 minutes
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from 8-14-60 , 19, to 8-14-60 , 19, that I last saw the deceased alive on 8-14-60 , 19, and that death occurred at 8:20 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED 8-15-60
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ACTUAL SIGNATURE <i>William F Krone Jr.</i>	PHYSICIAN'S NAME (Type) Frank William KRONE, Jr.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 18th 1960	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Memorial	22d. LOCATION (City, town, or county) Annapolis Md
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23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR AUG 17 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
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Editorial

References

References

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Journal of Health Politics, Policy and Law, Vol. 32, No. 4, December 2007
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8737

CERTIFICATE OF DEATH

08674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN lb <u>2 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Green Gables)</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1825 Pleasantville Dr.</u>		d. STREET ADDRESS <u>Box # 4 Rt. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <u>WILLIAM</u>	Middle <u>G.</u>	Last <u>ARAND</u>	4. DATE OF DEATH Month <u>August</u>	Day <u>12</u>	Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>4th Aug. 1883</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
8. WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter(ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown (Arand)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-0283</u>		17. INFORMANT <u>Mrs. Maud Never, 1625 Pleasantville Dr.</u>	Address <u>Glen Burnie, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Carcinoma of prostate with wide spread metastasis</u>		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Glen Burnie</u>	(County) <u>Md</u>	(State) <u>Maryland</u>
21. I certify that I attended the deceased from <u>Aug 1 1960</u> to <u>Aug 13 1960</u> that I last saw the deceased alive on <u>Aug 13 1960</u> , and that death occurred at <u>3 AM</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Morton M. Geiger</u> ADDRESS (Street, city or town, state) M.D. <u>5210A Ritchie Hwy - 25</u> DATE SIGNED <u>8/15/60</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>16 Aug. 60</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Singlet</u>		ADDRESS <u>Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Hunt</u>		

BY ROBERTS—MEMPHIS STATE UNIVERSITY

HAGG-DISTRICTED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08675

8738

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>HUVE BRUNDEL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. MARGARETS</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X ST. MARGARETS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>BELFIELD FARM</i>		d. STREET ADDRESS <i>BELFIELD FARM</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MATHILDE</i>	Middle <i>G</i>	Last <i>BARCHET</i>
4. DATE OF DEATH			August 29 1960
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-1873</i>
9. AGE (In years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. Year Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>CARL FRIEDRICH GROSSELT</i>		14. MOTHER'S MAIDEN NAME <i>MATHILDE P. BARCHET</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>MRS. W.W. Warlick</i>		Address <i>1510 Charles St. Annapolis MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>	
DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>Antherosclerotic C. V. Disease</i> <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>August 15, 1959</i> , to <i>Aug. 29, 1960</i> . that (I) (we) last saw the deceased alive on <i>Aug. 15, 1960</i> , and that death occurred at <i>6A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>Sept 10, 1960</i>	
22a. SIGNATURE <i>Maurice Klawans</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS</i>		22d. ADDRESS <i>31 SOUTH GATE AVE.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8-31-60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Family Cemt.</i>		23d. LOCATION (City, town, or county) <i>ST. MARGARETS, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. & Sons Annapolis, Md.</i>		ADDRESS <i>—</i>	
25a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

27820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

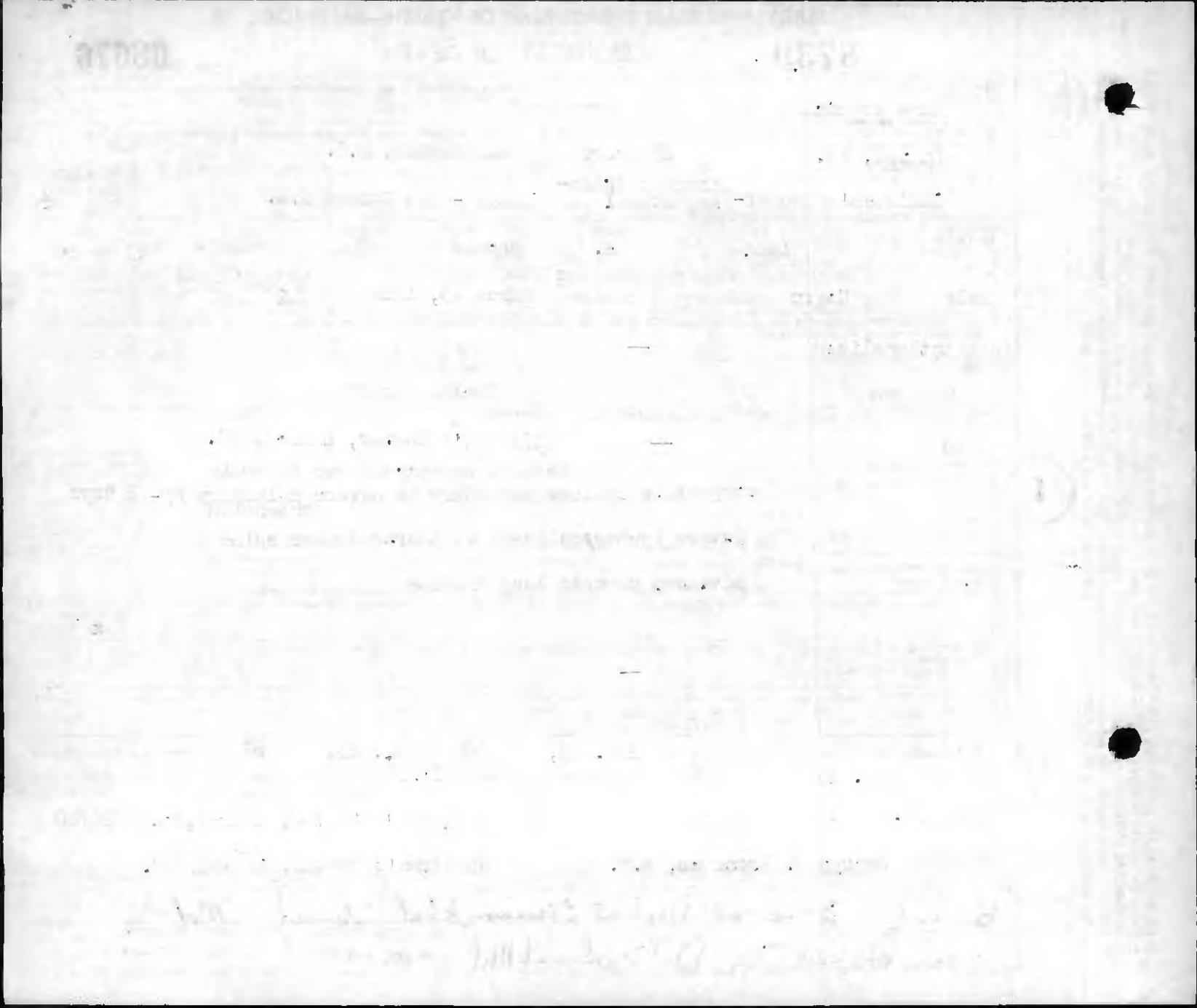
Items 11, 12, Film G270 9-6-60 et

8739

CERTIFICATE OF DEATH

Reg. Dis No 08676

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN lb 29 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 434 - 1st Street S.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center				d. STREET ADDRESS 434 - 1st Street S.W.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leon	Middle E.	Last Barnes	4. DATE OF DEATH	Month August	Day 25	Year 1960
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1918	9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Evelyn Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		INFORMANT Children's Center, Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive failure secondary to severe pulmonary hypertension - 2 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe kyphoscoliosis of thoracolumbar spine DUE TO (c) Advanced chronic lung disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 23, 1960 , to Aug. 25, 1960 , that I last saw the deceased alive on Aug. 24, 1960 , and that death occurred at 3:13 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) George T. Economos DATE SIGNED 8/26/60							
ACTUAL SIGNATURE George T. Economos		M.D. Children's Center, Laurel, Md. 8/26/60					
PHYSICIAN'S NAME (Type) George T. Economos, M.D.		Children's Center, Laurel, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8-26-60		22c. NAME OF CEMETERY OR CREMATORIAL District Training School		22d. LOCATION (City, town, or county) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE John W. McWhorter DTS Laurel Md							
ADDRESS				24a. REC'D BY REGISTRAR Calvin S. Kraus		24b. REGISTRAR'S SIGNATURE Calvin S. Kraus	
DATE AUG 30 '60							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08677

Reg. Dist. No.

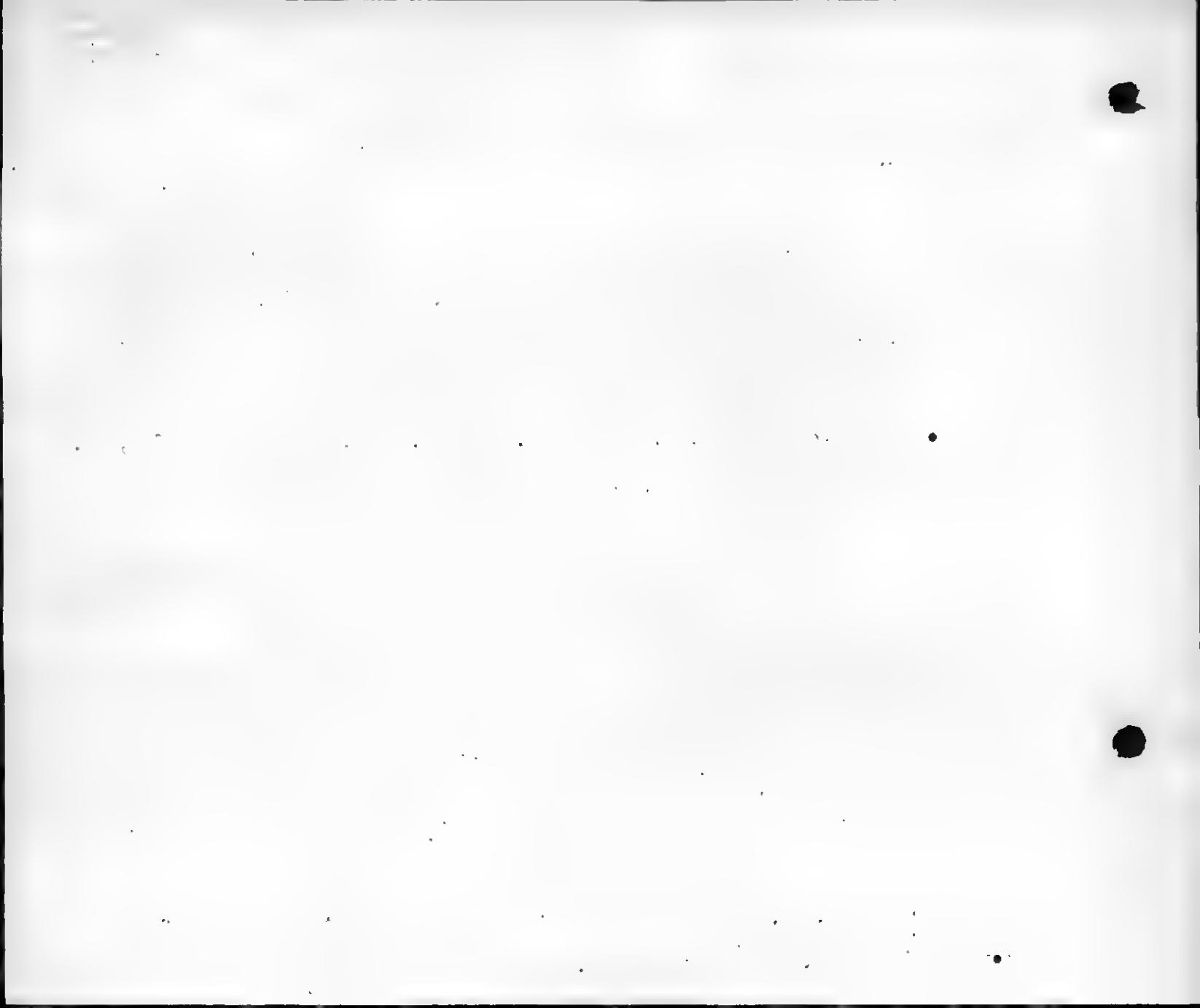
CERTIFICATE OF DEATH

8744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ODENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KM LT. GAGGIO JEWELL HOM		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZA	Middle ETH	Last BEACH
4. DATE OF DEATH	Month AUGUST	Day 21	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? , 1860
9. AGE (In years last birthday) 100 yrs	10. IF UNDER 1 YEAR Months 100	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. OLIVE W. King, Friend, Gambrills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intermission free valvular heart disease</i> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 10 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Dry skin</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>falling</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 21, 1960</i> to <i>August 21, 1960</i> , that I last saw the deceased alive on <i>August 21, 1960</i> , and that death occurred at <i>7:45 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cashfield DATE SIGNED 8/22/60			
ACTUAL SIGNATURE <i>John Hedman</i>	M.D.	22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 23, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		24a. REC'D BY REGISTRAR AUG 24 '60	24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>
ADDRESS Annapolis, Md.		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8678

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, exhumation, or removal.

1. PLACE OF DEATH a. COUNTY A.A.R.O.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) O.O.H. Anne Arundel General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17-4122	
3. NAME OF DECEASED (Type or print) Walter Bibbins		4. DATE OF DEATH 8 20 1960	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M.	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1919
9. AGE (in years at time of death) 59 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Captain		10b. KIND OF BUSINESS OR INDUSTRY Shipping	11. BIRTHPLACE (State or foreign country) Accomac Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAIAH BIBBINS	
14. MOTHER'S MAIDEN NAME MAGGIE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. William Bibbins 2129 W. North Ave		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Lohrhardt</i>		DATE SIGNED <i>8/20/60</i>	
EXAMINER'S NAME (Type) <i>E. L. Lohrhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/1960	22c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary
22d. LOCATION (City, town, or county) H.O.W. MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Monsignor P. Hayes 638 N. Gilmor St</i>		ADDRESS <i>Monsignor P. Hayes 638 N. Gilmor St</i>	24a. REC'D BY REGISTRAR DATE JUG 23 '60
		24b. REGISTRAR'S SIGNATURE <i>J. J. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08679

8741

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, interment, or removal.

M

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		d. STREET ADDRESS <u>Riva Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riva Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Donald</u>		First <u>D</u>	Middle <u></u>	Last <u>Brattain</u>	4. DATE DEATH <u>August 13</u>	Month <u>August</u>	Day <u>13</u> Year <u>1960</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1920</u>	9. AGE (in years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Travel Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Travel Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul H. Brattain</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Morris</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Paul H. Brattain</u>		17. INFORMANT <u>Paul H. Brattain</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture skull</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u></u> DUE TO (c) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently lost control of the car on wet pavement, skidde</u> <u>d off the road and hit a tree.</u>					
20c. TIME OF INJURY Hour <u>4:22</u> a.m. <u>8/13</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Riva Rd. Rte 450 nr. Annapolis</u>		(City or town) <u>AA</u>	(County) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>8-13-60</u>					
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 17 1960</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton Sons</u>		ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>REC'D BY REGISTRAR</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hart</u>	
VS. A15ME(5)		DATE AUG 18 '60					
5M 9/55							

7

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

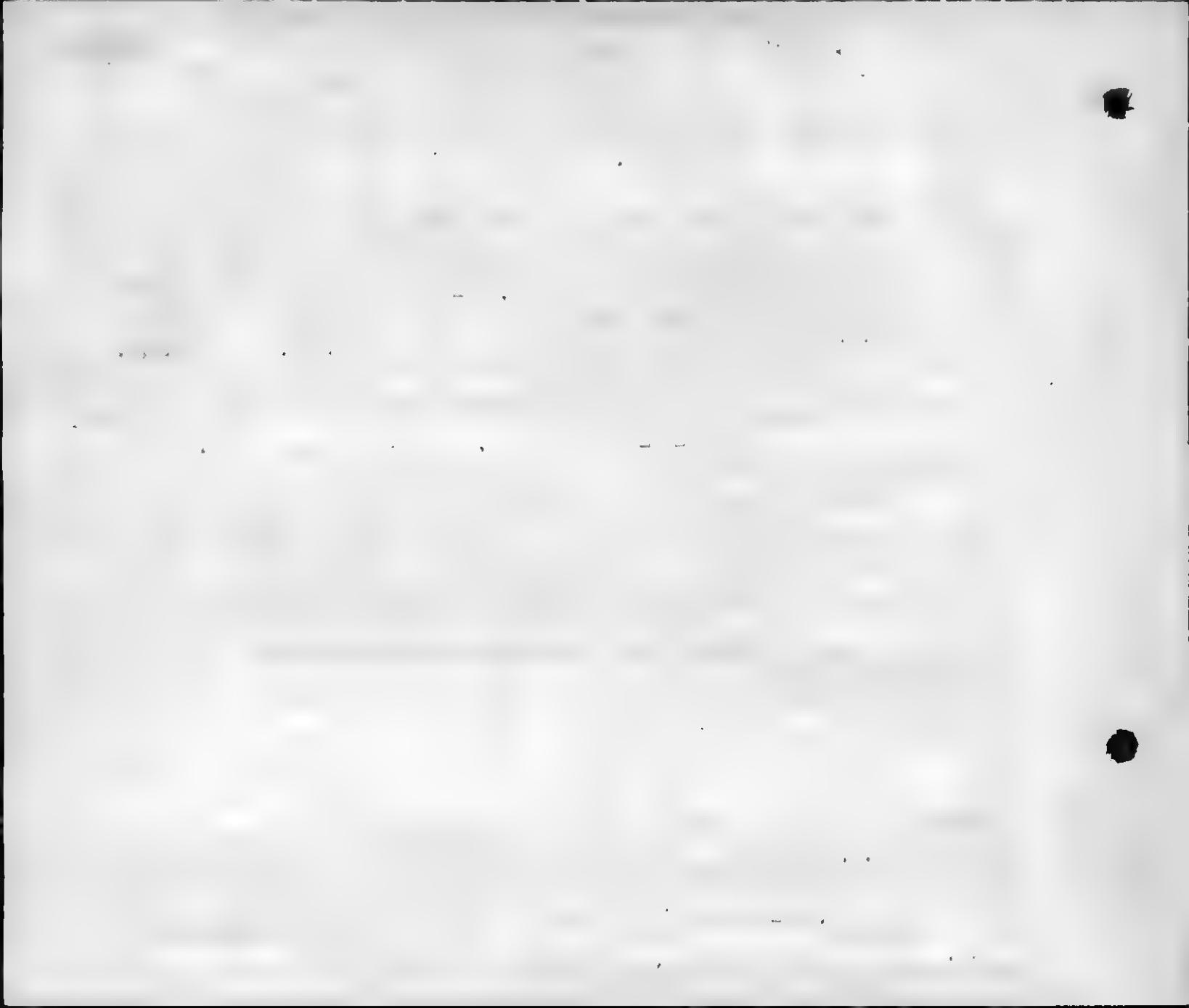
8695

CERTIFICATE OF DEATH

08680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) College Creek Terrace		d. STREET ADDRESS 62 College Creek Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Henry Brown		First	Middle
4. DATE OF DEATH August 10		Last	Month
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 30-1885		9. AGE (in years last birthday) 74	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Utilities		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Brown		14. MOTHER'S MAIDEN NAME Serena Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-16-0625	17. INFORMANT Edna S. Brown - 62 College Crk. Terrace
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Disease It's due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterial sclerosis (arteriosclerosis) (as. s.)		INTERVAL BETWEEN ONSET AND DEATH 1-2 wks	
DUE TO Arterial sclerosis (arteriosclerosis) (as. s.)		(b) Arterial sclerosis (arteriosclerosis) (as. s.)	
DUE TO Arterial sclerosis (arteriosclerosis) (as. s.)		(c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1145 1/4
20f. (City or town) Annanolis		(County) Md.	
(State) Md.			
21. I certify that I attended the deceased from August 10 , 1960, to August 10 , 1960, that I last saw the deceased alive on August 10 , 1960, and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clay Street Annapolis, Maryland	
ACTUAL SIGNATURE R.L. Richardson		DATE SIGNED Aug. 16 '60	
PHYSICIAN'S NAME (Type) R.L. Richardson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13-60	22c. NAME OF CEMETERY OR CREMATORIUM Bruwer Hill
22d. LOCATION (City, town, or county) Annapolis, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 Annapolis, Md.		24a. REC'D BY REGISTRAR Aug. 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be rendered by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, or, page 3 should be detached and used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08681

8696			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Annapolis		Maryland	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
RURAL and give nearest town)		Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
General Hospital		28 Shaw Street	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Elizabeth		Brown	8
FIRST	MIDDLE	MONTH	DAY
Female	Col	1960	2
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-6-1906
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
34 yrs	Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address	
Alexander Abrahams	Elsie Hopkins	Joseph Brewer 28 Shaw St.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
(If yes, give war or dates of service)			260X Due to Gremia
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b)	DUE TO	Nephritis
	(c)	DUE TO	Diabetes Mellitus (Died) 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Atherosclerosis & hypertension Cardiopathy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19		9/26 1956	to 8-20 1960
21. I certify that (I) (this hospital) attended the deceased from Aug. 2 1960, and that death occurred at M, from the causes and on the date stated above	22a. SIGNATURE		
	Steve W. Gillen M.D.		
22c. PHYSICIAN'S NAME (Type)	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS
22d. ADDRESS	62 Cathedral St Annapolis MD		
23a. BURIAL, CREMATION OR REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCAT ON (City, town or county) (State)
Burial 8-5-1960	Brewer Hill	Cathedral	Annapolis MD
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE DATE
William R. Resett Anna, MD		AUG 4 '60	John S. Gillen



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dm. No. 08682

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY A.A. CO.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel Gen		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - MD 3 Vol			
3. NAME OF -DECEASED (Type or print) John		d. STREET ADDRESS 2511 N. Calvert			
4. DATE OF DEATH 8		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M		6. COLOR OR RACE W			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1908			
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10b. KIND OF BUSINESS OR INDUSTRY Weiskettle Co			
11. BIRTHPLACE (State or foreign country) Baltimore County, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Brownlee		14. MOTHER'S MAIDEN NAME Elizabeth Curran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-5890			
17. INFORMANT Mrs. Mary F. Brownlee, 2511 N. Calvert Street		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac disease		INTERVAL BETWEEN ONSET AND DEATH Sudden			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/14/60	
22a. BURIAL, CREMATION, BURIAL (Specify)		22b. DATE THEREOF 8-18-60		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
22d. LOCATION (City, town, or county) A.A. County, Md				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8698

CERTIFICATE OF DEATH

18683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
<i>A. A. Annapolis Maryland</i>		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Annapolis</i>		<i>Rural - Broadwater Co.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
<i>A. A. Hosp. Hosp.</i>		<i>Annapolis, Md.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle		
<i>Evie</i>		<i>Buckmaster</i>	<i>Last</i>		
4. DATE OF DEATH		Month	Day Year		
		<i>8</i>	<i>14 1960</i>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
<i>M</i>		<i>W</i>	<i>5-16-92? 683 yrs.</i>		
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
		<i>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</i>	<i>10b. KIND OF BUSINESS OR INDUSTRY</i>	<i>11. BIRTHPLACE (State or foreign country)</i>	<i>12. CITIZEN OF WHAT COUNTRY?</i>
		<i>Robert Goode</i>	<i>Arnold Sta</i>	<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
<i>John B Buckmaster</i>		<i>Eunice Bettis</i>		<i>Arnold Sta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ex. no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)		<i>100-03-4925</i>		<i>Bertrude Goode Buckmaster</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ischaemic coronary occlusion</i> DUE TO <i>5-10-1</i>		<i>5 min.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary artery insufficiency</i> DUE TO <i>5-10-1</i>		<i>5 min.</i>			
(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1960</i> to <i>August 1960</i> , that I last saw the deceased alive on <i>July 11 1960</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John B. Goode</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St., Baltimore, Md.</i>			
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>Sept 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-17-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore</i>	22d. LOCATION (City, town, part county) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>Aug 17 '60</i>	24b. REGISTRAR'S SIGNATURE	
<i>Edward Johnson 2359 West Blvd</i>		<i>Baltimore</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

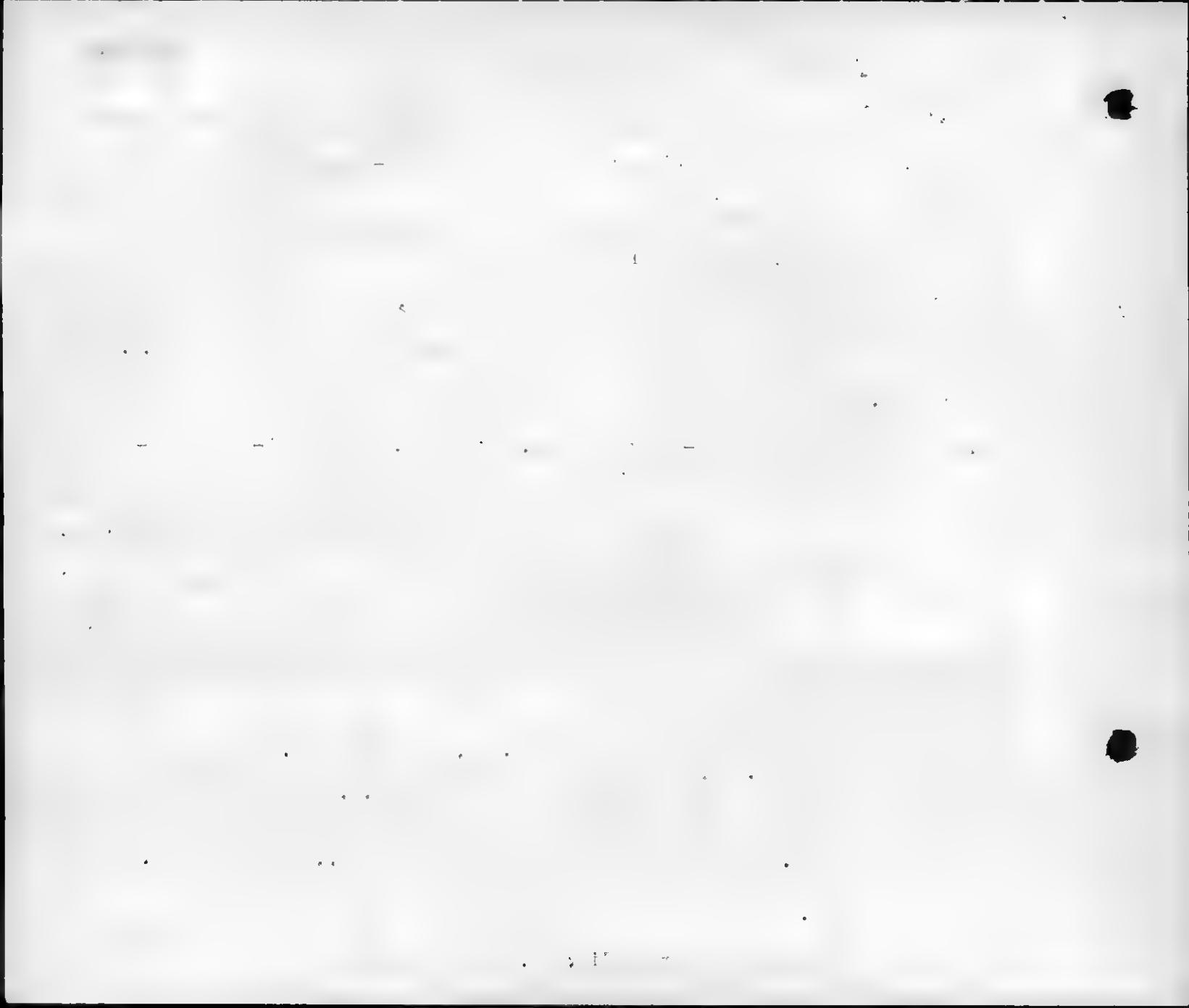


1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
8699				08684									
1. PLACE OF DEATH <input checked="" type="checkbox"/> COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <input checked="" type="checkbox"/> STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 days									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Elizabeth				First L		Middle		Last BULL		4. DATE OF DEATH August 30 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, 1895		9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales-lady				10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oliver S. League				14. MOTHER'S MAIDEN NAME Ida Fouche									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-24-3336				17. INFORMANT Mrs. Rosella B. Stinchcomb - Daughter Mayo, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Pulmonary edema - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				INTERVAL BETWEEN ONSET AND DEATH 1 hr.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Due to Heart Failure - Chronic Coronary heart disease, Chronic													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f (City or town)		(County)		(State)			
21. I certify that (I) (initials) attended the deceased from Aug. 20, 1960, to Aug. 30, 1960, that (I) (initials) last saw the deceased alive on Aug. 30, 1960, and that death occurred at _____ M. from the causes and on the date stated above				22b. DATE SIGNED 8/31/60									
22a. SIGNATURE <i>Dr. Christopher</i>				ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) Stuart M. Christopher				22d. ADDRESS 69 Franklin St., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 3, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Mayo Memorial Cemetery				23d. LOCATION (City, town, or county) Mayo, Maryland				(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 6 '60		25b. REGISTRAR'S SIGNATURE <i>Christopher S. Thomas</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8742

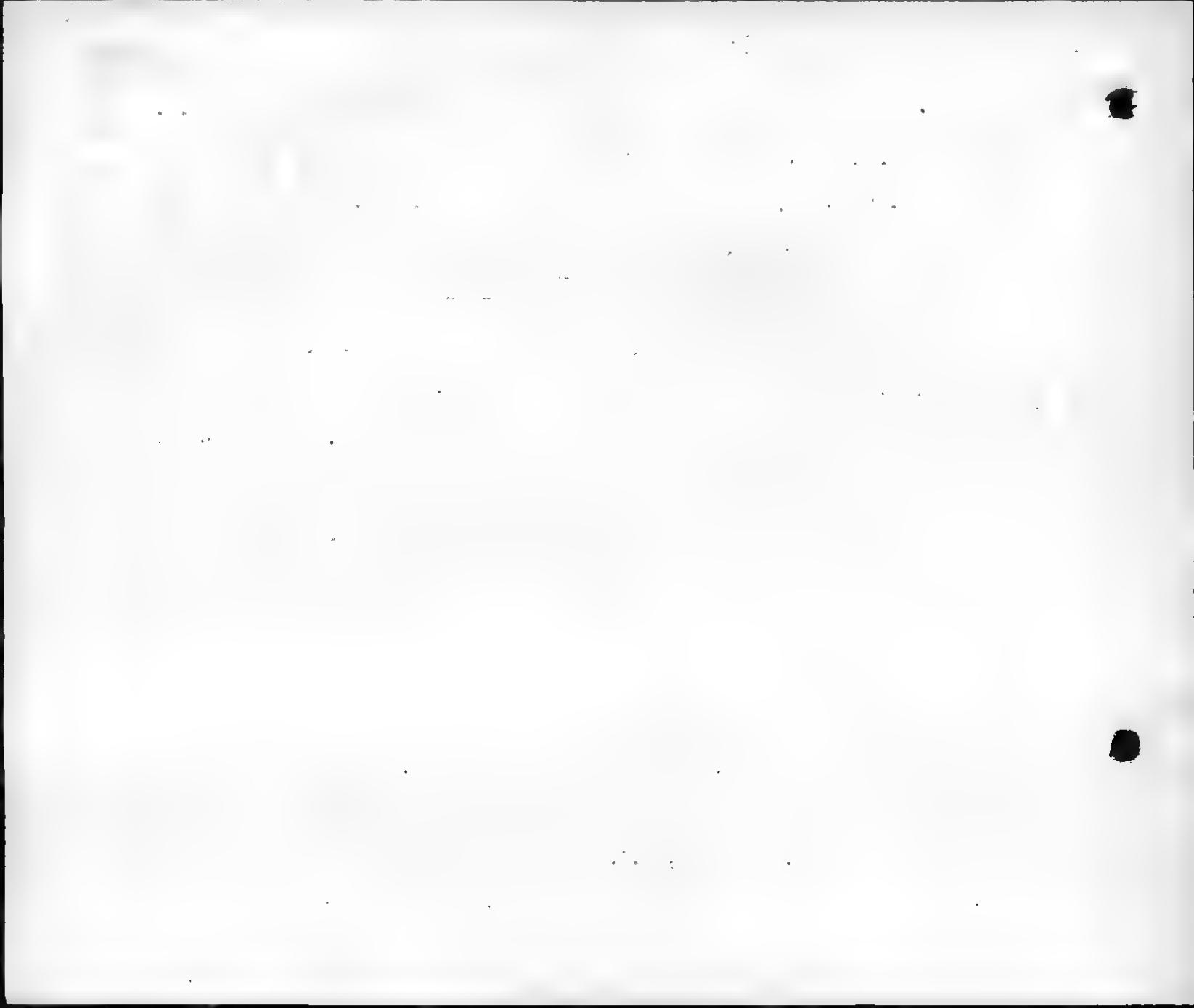
CERTIFICATE OF DEATH

Reg. Dist. No. 08685

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: As his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Children's Center Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Tyrohe	Middle Ellsworth	Last Butler
4. DATE OF DEATH	Month ■	Day 12	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-44
9. AGE (In years last birthday) 16 yrs.	10. IF UNDER 1 YEAR Months 16	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inmate	10b. KIND OF BUSINESS OR INDUSTRY Institution	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ellsworth Gibbons		14. MOTHER'S MAIDEN NAME Inez Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO	INFORMANT Children's Center Records	Address Laurel, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe nutritional anemia			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002X			
(b) Pulmonary congestion with terminal weeks pneumonia.			
DUE TO (c) Possibility of Pulmonary T.b.c to be considered			
INTERVAL BETWEEN ONSET AND DEATH several weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Cerebral Critical Atrophy secondary to birth injury.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-11- , 19 60 , to 8-12 , 19 60 , that I last saw the deceased alive on 8-12- , 19 60 , and that death occurred at 8:22 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Economos</i>		ADDRESS (Street, city or town, state) Children's Center Hospital	
PHYSICIAN'S NAME (Type) George T. Economos, M.D.		DATE SIGNED Laurel, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/60	22c. NAME OF CEMETERY OR CREMATORIUM Children's Center Cemetery	22d. LOCATION (City, town, or county) Laurel (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hoone Jr. D.T.S. Laurel</i>		24a. REC'D BY REGISTRAR DATE AUG 18 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kuhn</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8743

CERTIFICATE OF DEATH

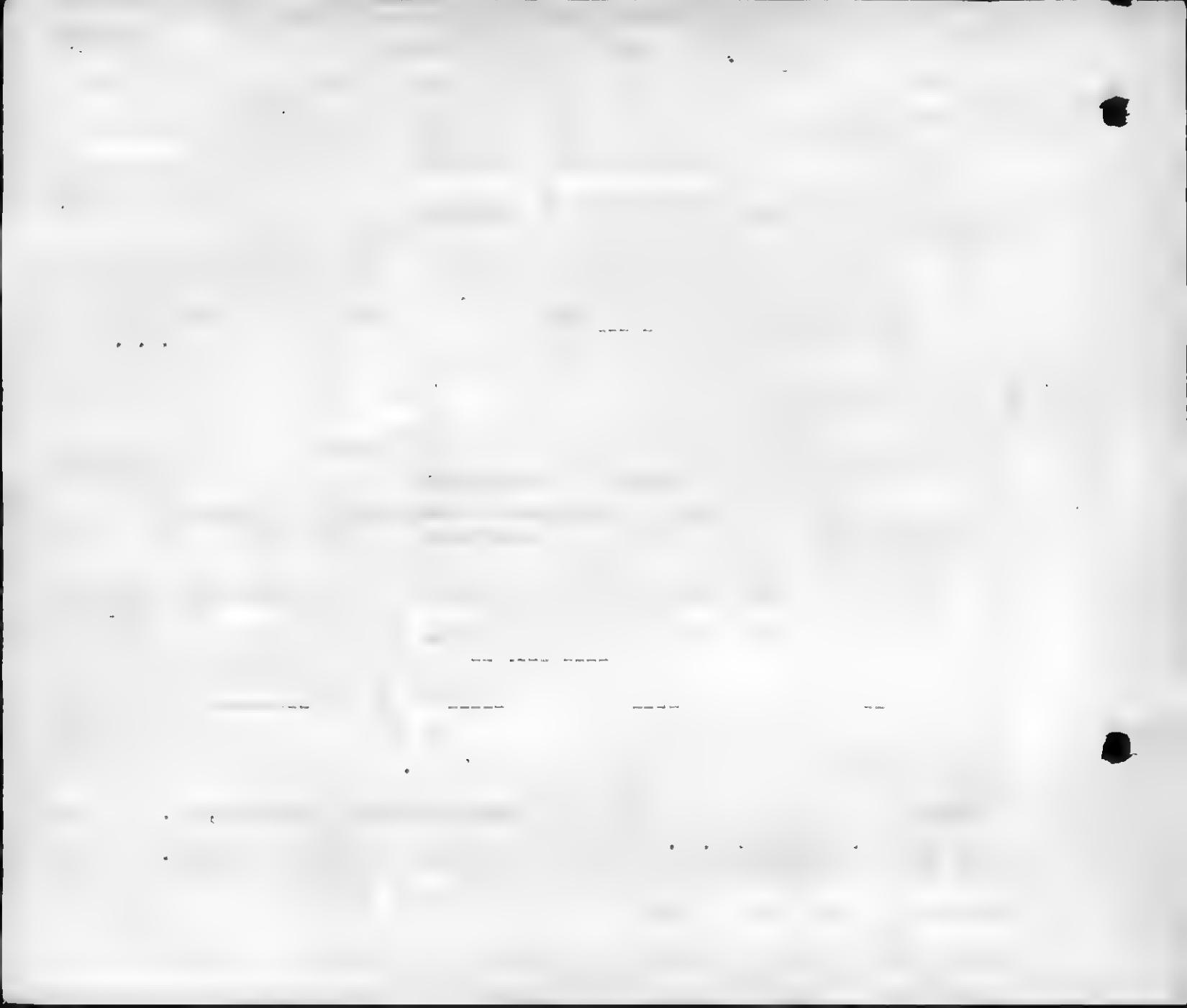
08686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 5 months 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		d. STREET ADDRESS Unknown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Henry Butler		First	Middle	Last	4. DATE OF DEATH 8 30 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1903	9. AGE (In years, last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Maxwell Butler				14. MOTHER'S MAIDEN NAME Cora ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Dehydration & Emaciation				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Chronic Brain Syndrome Associated with Alcoholic Intoxication						
DUE TO (c)								
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- 19 p. m. -----		20d. INJURY OCCURRED White <input type="checkbox"/> Negro <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Louis Pond, Com.		20f. (City or town) -----		(County) (State)
21. I certify that I attended the deceased from _____ 3/9 _____, 1960, to 8/30, 1960, that I last saw the deceased alive on _____ 8/30, 1960, and that death occurred at 1:34 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <i>Benedict M.</i>				MD		Crownsville State Hospital, Md.		8/30/60
PHYSICIAN'S NAME (Type) L. Benedict, M. D.						Crownsville State Hospital, Md.		8/30/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/60		22c. NAME OF CEMETERY OR CREMATORIUM St. Louis Pond, Com.		22d. LOCATION (City, town, or County) St. Louis Pond		(State) 7/10
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth W. Wiley</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 2 '60		24b. REGISTRAR'S SIGNATURE Charles S. Turner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. There please remove carbon paper. Pages 1 and 2 should be left with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

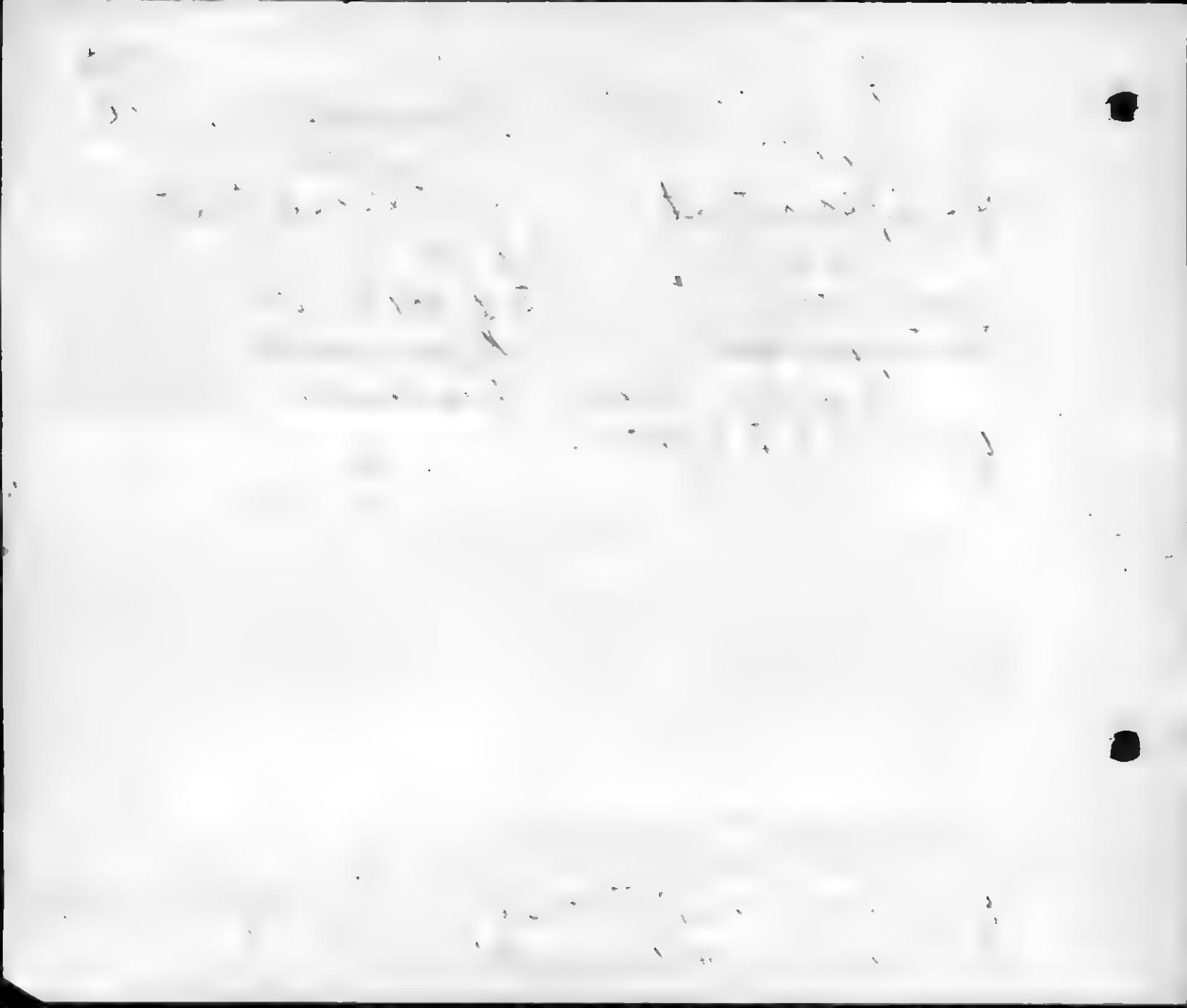
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TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8700		08688	
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County Maryland</i>		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>44 Pleasant St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>44 Pleasant St.</i>		e. STREET ADDRESS <i>44 Pleasant St.</i>	
3. NAME OF DECEASED (Type or print) <i>Clarence Carr</i>		4. DATE OF DEATH Carr 8 Month Day Year <i>3-4-1893 67 31 1960</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-4-1893</i>	
10a. USUAL OCCUPAT.ON (Give kind of work done during most of working life, even if retired) <i>Electrician Helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Carr</i>		14. MOTHER'S MAIDEN NAME <i>Luvenia Carr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W.I 212-149170A</i>	
17. INFORMANT <i>John Stewart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Esophagus</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
DUE TO (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19____, that (I) _____ last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		22b. DATE SIGNED <i>9/1/60</i>	
22a. SIGNATURE <i>R. Richardson</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. Richardson MD</i>		22d. ADDRESS <i>110-0 Bay St Annapolis Md</i>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial 9-6-1960</i>		23b. DATE THEREOF <i>National</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Carr</i>		23c. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
		25a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Linus S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08687

Reg. Dist. No.

8701

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
aa MARYLAND		Md b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Annapolis Md		Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS					
136 Queen St	136 Queen St					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
Lillian Louise Cattin						
4. DATE OF DEATH	Month	Day	Year			
8 - 5			1960			
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH			
Female White		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov 5-1907			
9. AGE (In years last birthday) yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
52	Bar Tender	Baltimore Md	U.S.A			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
Niccum E. Cattin	Betty E. Courtney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
[If yes, give war or date of service]	213-22-014	Mrs John Thury	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Edward S. Beck</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 8/6/60		
EXAMINER'S NAME (Type) Edward S. Beck						
22a. FURAL, CREMATION, REMOVAL (Specify) Vehicle	22b. DATE THEREOF Aug 8-1960	22c. NAME OF CEMETERY OR CREMATORIAL Cracker Barrel	22d. LOCATION (City, town, or county) Annapolis Md	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons Annapolis Md	ADDRESS	24a. REC'D BY REGISTRAR Date AUG 10 '60	24b. REGISTRAR'S SIGNATURE C. Linn S. Knapp			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08689

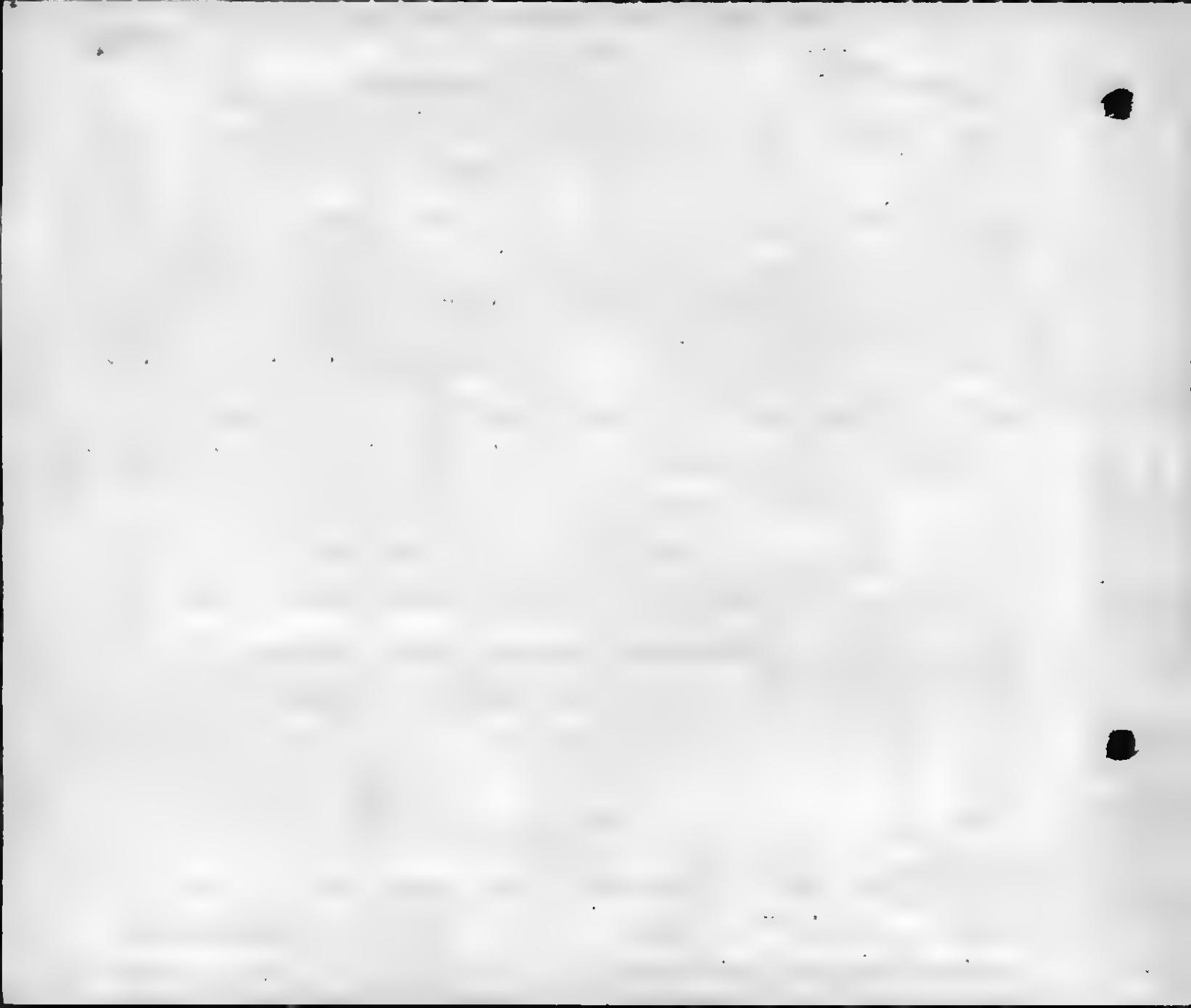
Reg. Dist. No.

8702

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE [Where deceased lived If institution: Residence before admission] a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		d STREET ADDRESS 4 Hickl Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Wesley	Last Chambers	
4. DATE OF DEATH	Month August	Day 7	Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16-1879	
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		
11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Wesley		14. MOTHER'S MAIDEN NAME Nancy Lane		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT John T. Chambers - 1 Hickl Ave., Annapolis, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45 yrs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchitis DUE TO (c) Encysted Adenocarcinoma		George's Heart Failure 15 yrs 15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		alive on _____ and that death occurred at _____, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE <i>Herdean H. Johnson</i>	M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1960	22c. NAME OF CEMETERY OR CREMATORIUM Brewer Hill	22d. LOCATION (City, town, or county) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hickl 111		ADDRESS Annapolis, Maryland	24a. REC'D BY REGISTRAR DATE AUG 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached and given to the funeral director. All other parts of this certificate have been signed by the attending physician. If either part of page 3 should be detached, use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8744

CERTIFICATE OF DEATH

Reg. Dist. No.

08690

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		
9 A		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McKendree		c. LENGTH OF STAY IN 1b 6 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McKendree		
3. NAME OF DECEASED (Type or print)		First	Middle	
DAVID		WALTER CHESS		
4. DATE OF DEATH	Month	Day	Year	
AUGUST 21	1960			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
M	W	WIDOWED <input checked="" type="checkbox"/>	5/21/82	
9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, 4 t.	10b. KIND OF BUSINESS OR INDUSTRY STATISTICIAN	11. BIRTHPLACE (State or foreign country) Pittsburgh Pa.	12. CITIZEN OF WHAT COUNTRY? La Jolla	
13. FATHER'S NAME DAVID CHESS	14. MOTHER'S MAIDEN NAME MARY STONE Boles	Address 1951 Ladera Way, La Jolla, Calif		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 040-20-1184	17. INFORMANT Mrs. C. T. Joy	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +92X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
mid pneumonitis acute myocardial failure			INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 8-19, 1960 to _____ 8-20, 1960, that I last saw the deceased alive on _____ 8-19, 1960, and that death occurred at _____ 89 M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Emily H. Klein</u> M.D. ADDRESS (Street, city or town, state) <u>Luthecan, Md</u> DATE SIGNED <u>8-22-60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8/23/60	22c. NAME OF CEMETERY, OR CREMATORIAL CATH. CHURCH	22d. LOCATION (City, town, or county) TOWNSHIP Vd.
23. FUNERAL DIRECTOR'S SIGNATURE Bertrand Hardisty, Helen Lee Reed		ADDRESS	24a. REC'D BY REGISTRAR AUG 25 '60	24b. REGISTRAR'S SIGNATURE C. H. & K.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

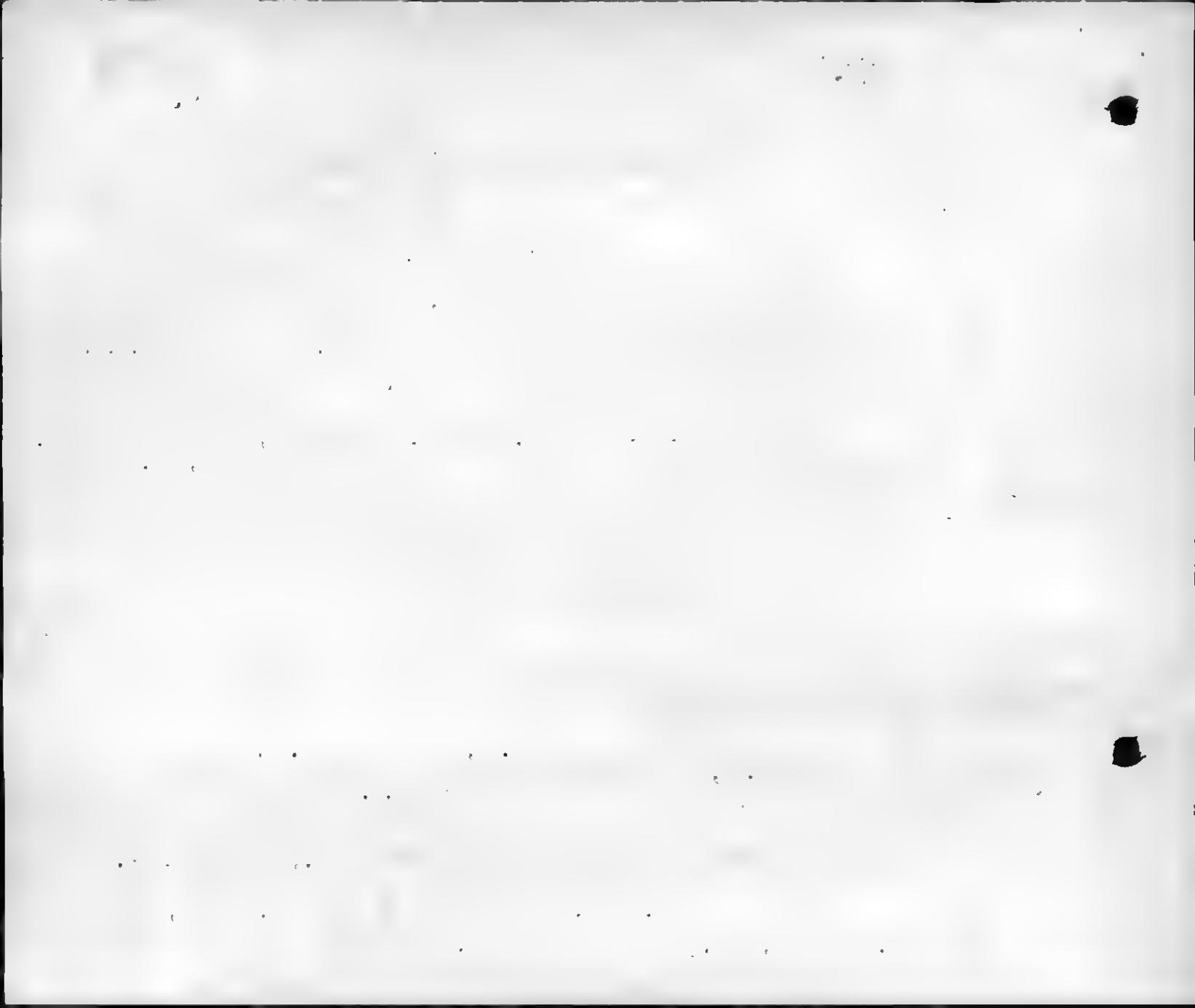
or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08691

1 PLACE OF DEATH a. COUNTY Anne Arundel		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 24 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) William		First William	Middle Einar
4. DATE OF DEATH August		Month 9	Day 19
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH January 1, 1918
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 42 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ormer		10b KIND OF BUSINESS OR INDUSTRY Gas Stations	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EINAR CHRISTENSEN		14. MOTHER'S MAIDEN NAME MABEL FENDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-01-8673	
17. INFORMANT Mrs. Coote L. Christensen, 8811 Glenville Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Myocardial infarction			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO converging arteriosclerosis			
DUE TO converging arteriosclerosis			
DUE TO converging arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1960, to Aug. 9, 1960, that (I) <input type="checkbox"/> last saw the deceased alive on Aug. 9, 1960, and that death occurred at M, from the causes and on the date stated above.		22a SIGNATURE G. Church	
22c PHYSICIAN'S NAME (Type) Gerald Church		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED 8/10/60
23a BURIAL CREMATION, REMOVAL (Specify) CREMATION		23b DATE THEREOF 8/12/60	23c NAME OF CEMETERY OR CREMATORIUM ST. MARY'S CEMETERY
24. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Ziska		ADDRESS SILVER SPRING, MD.	25a REC'D. BY REGISTRAR DATE AUG 15 1960
			25b REGISTRAR'S SIGNATURE Arthur L. Trahan

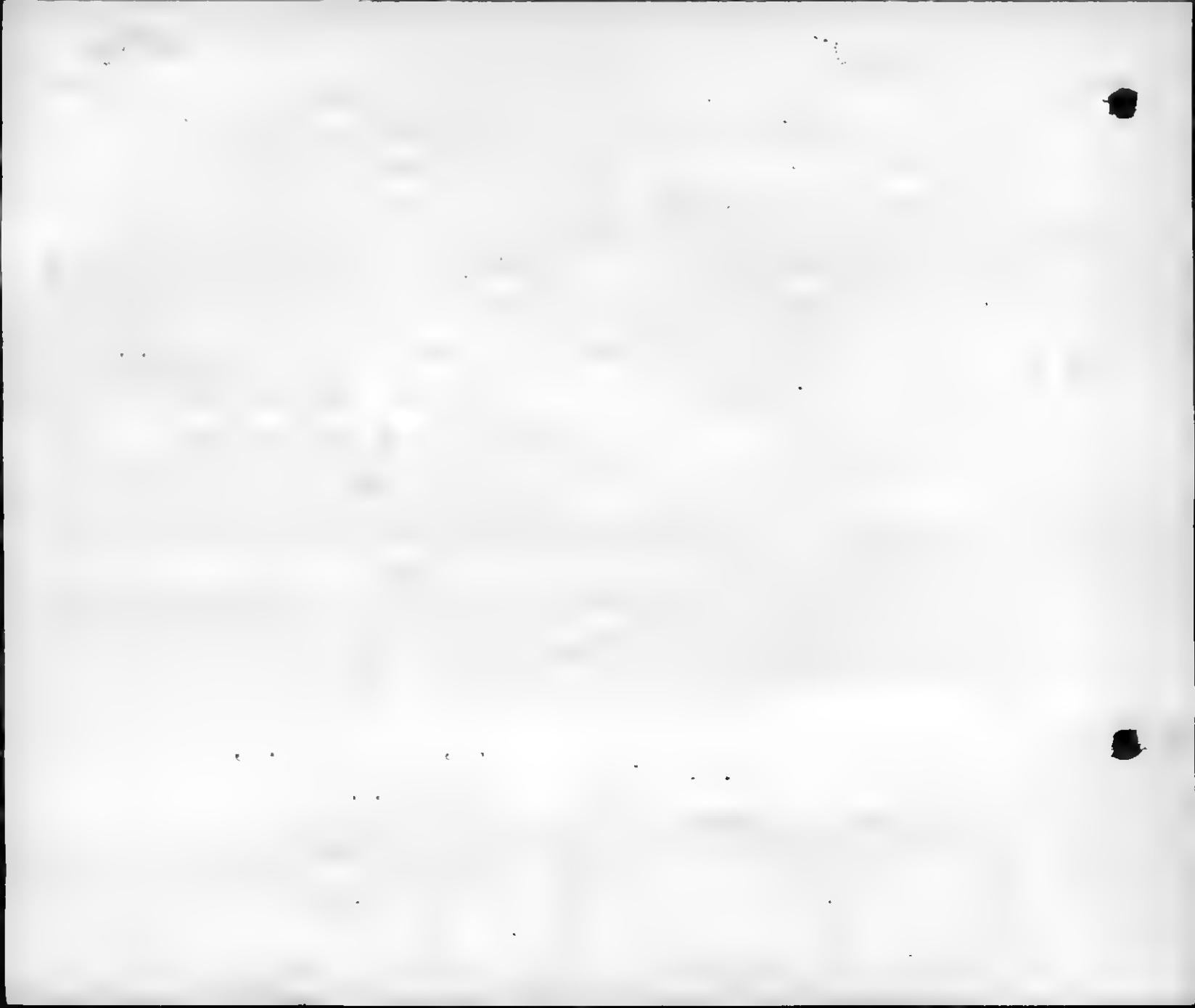


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8704

08692

1 PLACE OF DEATH o COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Anne Arundel	
Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Anne Arundel General Hospital		Mulberry Hill			
3 NAME OF DECEASED (Type or print)	First Mary	Middle	Last COATES	4. DATE OF DEATH	Month August Day 4 Year 1960
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH October 11, 1882	9 AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		House		Maryland	
13 FATHER'S NAME Dora Owens		14. MOTHER'S MAIDEN NAME Eliza Brown		12 CITIZEN OF WHAT COUNTRY? U.S.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO 7		Address	
(Yes, no or unknown) (If yes, give war or dates of service)		17 INFORMANT Della Cook Annapolis Md		INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		acute Pulmonary Edema			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		acute Coronary Artery Disease			
DUE TO (b)		DUE TO (c)			
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug. 3, 1960, to Aug. 3, 1960, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Aug. 4, 1960, and that death occurred at M, from the causes and on the date stated above					
22a. SIGNATURE <i>Ans T. Allen</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/4/60	
22c. PHYSICIAN'S NAME (Type) <i>Ans T. Allen</i>		22d. ADDRESS <i>C. Cookson Jr.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/8/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Auburn</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edward C. Wilson 1000 Brantley Ave</i>		ADDRESS <i>Edward C. Wilson 1000 Brantley Ave</i>		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Hayes</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **PAGE 4**

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8705

CERTIFICATE OF DEATH

08693

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 58 Pleasant Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle E.	Last Coates
4. DATE OF DEATH August 18 1960	Month Aug	Day 18	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1872
9. AGE (In years last birthday) 87 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Joseph Coates	14. MOTHER'S MAIDEN NAME Fannie Coates	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES, NO, OR UNKNOWN Yes	16. SOCIAL SECURITY NO Espousal American	17. INFORMANT Mary E. Coates 58 Pleasant St.	18. INTERVAL BETWEEN ONSET AND DEATH None
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastases</i> DUE TO (c) <i>CA Prostate</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/5/57</u> , 19 <u>60</u> , to <u>8/18</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8/8/60</u> , 19 <u>60</u> , and that death occurred at <u>115 M</u> , from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE <i>Edwin Davis Jr.</i>	M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) William Beesoff, Curnan M	22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-2360	23b. DATE THEREOF ADDRESS National	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town, or county) Annapolis Md
24. FUNERAL DIRECTOR'S SIGNATURE William Beesoff, Curnan M	25a. REC'D BY REGISTRAR DATE AUG 24 '60	25b. REGISTRAR'S SIGNATURE John S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8745

08694

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A.M.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore River</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore River Edgewater</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.O. Co. Home</i>		d. STREET ADDRESS <i>A.O. Co. Home</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Henrietta</i>	Middle <i>Rogers</i>	Last <i>Craig</i>	4. DATE OF DEATH <i>Oct 3, 1874</i>	Month <i>Oct</i>	Day <i>3</i>	Year <i>1874</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct 3, 1874</i>	9. AGE (in years from birthday) <i>83</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Churchton Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>James W. Rogers</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Phillips</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>604-07-0001</i>		17. INFORMANT <i>George Craig</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis Cardio Vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Annapolis</i>	(County) <i>Annapolis</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1874</i> to <i>Aug 3, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 1, 1874</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Maurice F. Kawans</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>8/6/60</i>						
22c. PHYSICIAN'S NAME (Type) <i>MAURICE F. KAWANS, MD</i>		22d. ADDRESS <i>31 Southgate St., Annapolis, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 6, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bay Cemetery</i>		23d. LOCATION (City, town or county) <i>Annapolis</i>		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob M. Taylor Son</i>		ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i>		25b. REGISTRAR'S SIGNATURE <i>C. Elmer S. Kraus</i>					



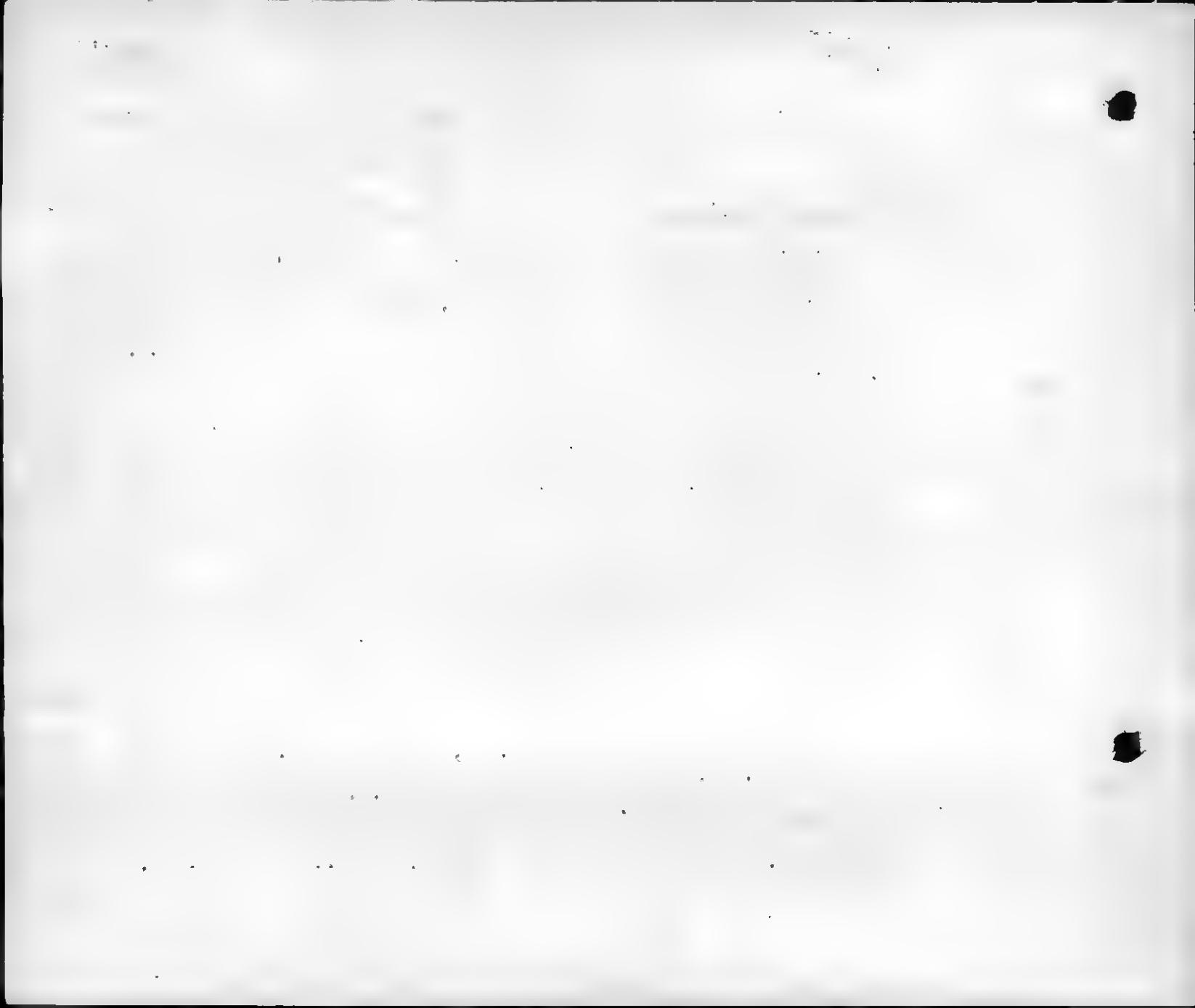
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8706

08695

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie	First Lillie	Middle M.	Last CURRAN
4. DATE OF DEATH August 31 1960	Month August	Day 31	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John R. Gouche		14. MOTHER'S MAIDEN NAME Annie P. Medford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT John R. Taylor ②	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE HEART DISEASE; DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Edward S. Beck attended the deceased from Aug. 17, 1960 to Aug. 30, 1960, that (I) had last saw the deceased alive on Aug. 30, 1960, and that death occurred at M, from the causes and on the date stated above			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 2-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Bluff Cemt		23d. LOCATION (City, town, or county) Annapolis (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. ADDRESS Annapolis Md.	
25b. REC'D BY REGISTRAR DATE SEP 2 '60		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

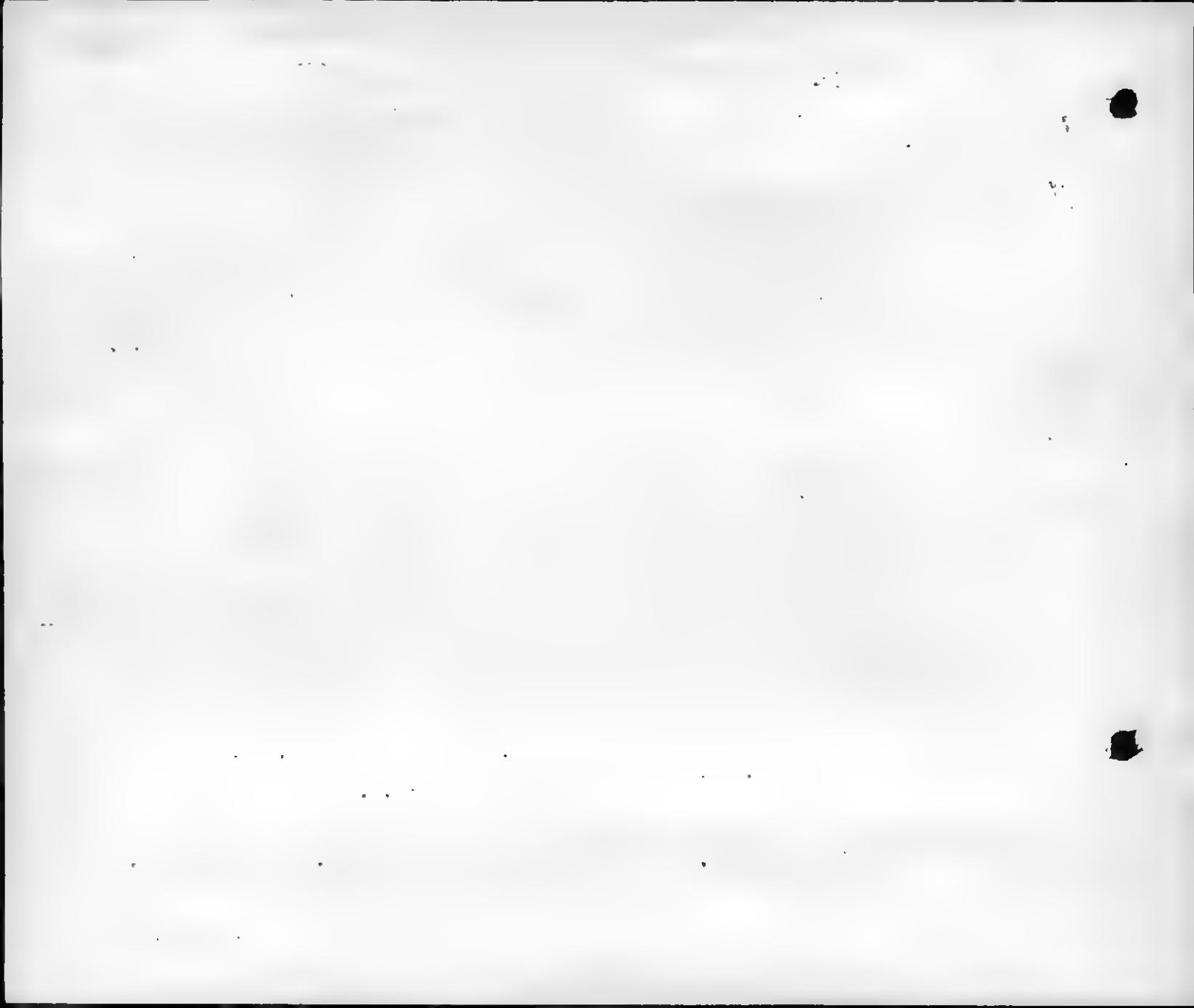
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08696

8707		Items 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24	
1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1B 70 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		First	Middle
4. DATE OF DEATH DAVIS		Last	Month August
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 17, 1883		9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY ICE PLANT	10c. BIRTHPLACE (State or foreign country) Maryland
11. CITIZEN OF WHAT COUNTRY? U.S.		12. FATHER'S NAME Unknown	
13. MOTHER'S MAIDEN NAME Unknown		14. INFORMANT 21305026414 yrs Della Davis Galesville Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		18. INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary failure CA lung (metastases)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. Aug. 16, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 98 Cathedral St., Annapolis, Md.	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from Feb. 20, 1960 to Aug. 16, 1960 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Aug. 16, 1960 , and that death occurred at M , from the causes and on the date stated above		22b. DATE SIGNED 8/23/60	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.		22d. ADDRESS 98 Cathedral St., Annapolis, Md.	22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/19/60	
23c. NAME OF CEMETERY OR CRYPT Burialot Sorrows		23d. LOCATION (City, town or county) Galesville	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		25a. REC'D. BY REGISTRAR AUG 26 '60	25b. REGISTRAR'S SIGNATURE John J. Keane
ADDRESS Hallards ed		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8746

CERTIFICATE OF DEATH

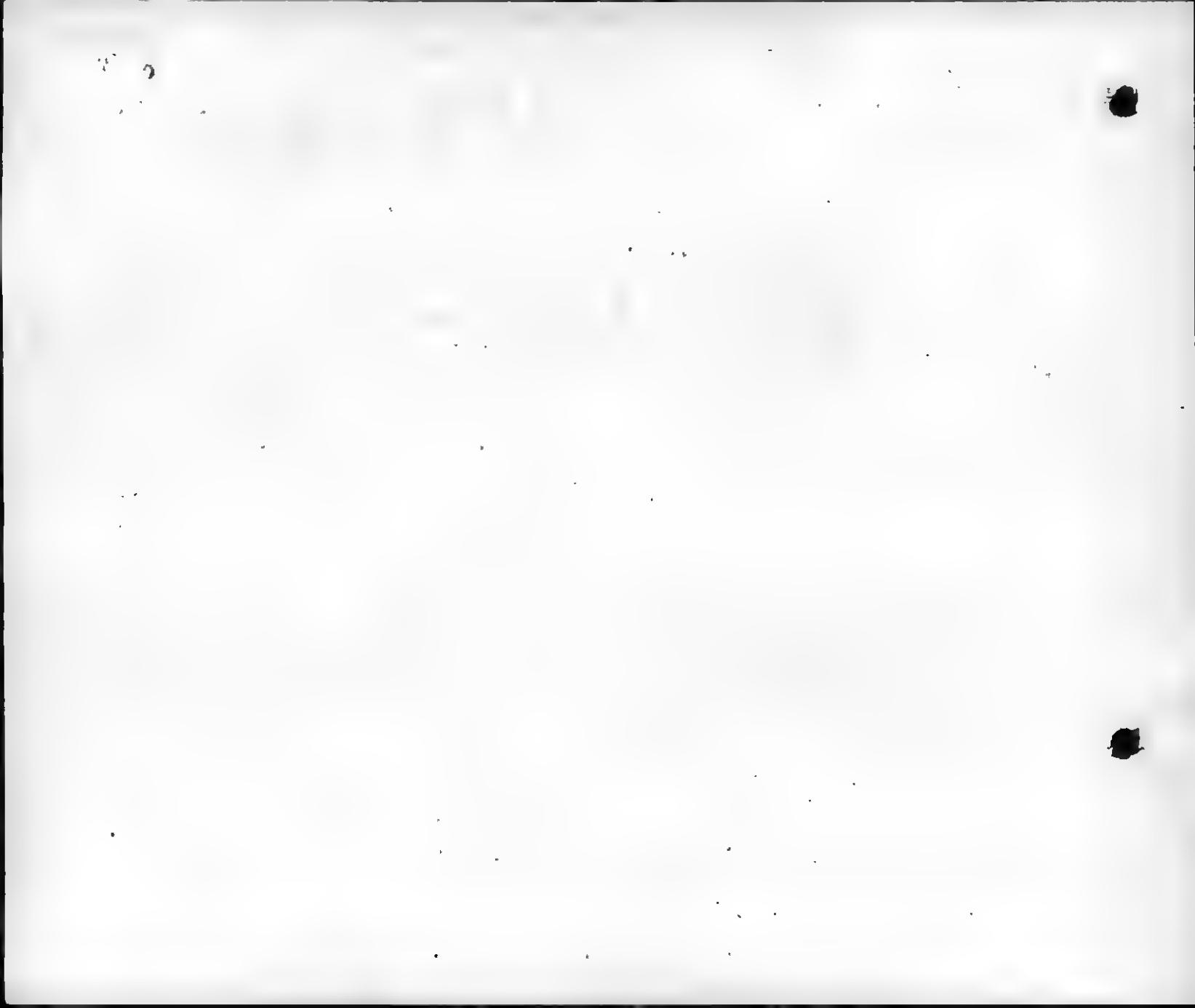
08697

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) o STATE Maryland b. COUNTY A. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	c LENGTH OF STAY IN 1b Life	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Nagogly, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 511 Pasadena, Md.	d. STREET ADDRESS Box 511 Pasadena, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James Henry Edwards	First	Middle	Last		
4. DATE OF DEATH August 27, 1960	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1896	9. AGE (In years lost birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pasadena, Maryland	
13. FATHER'S NAME Willie Edwards			14. MOTHER'S MAIDEN NAME Annie Edwards		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT Dolia E. Edwards Box 511 Pasadena, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> to <u>August 25, 1960</u> at <u>Johns Hopkins Hospital</u> , M. D., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Lily Toole</u> ADDRESS (Street, city or town, state) <u>Baltimore, Maryland</u> DATE SIGNED <u>8/29/60</u>					
PHYSICIAN'S NAME (Type) W.M. NISBET TOOLE MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) N/A		22b. DATE THEREOF Sept. 1, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Nagogly Church Cemetery	
22d. LOCATION (City, town, or county) Pasadena, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson Funeral Home Inc.		ADDRESS 915 Pa. Ave.		24a. REC'D BY REGISTRAR DATE SEP 2 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8708

08698

1. PLACE OF DEATH o COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 6 hours						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park						
3. NAME OF DECEASED (Type or print) Elmer JOHN W. ELMER		d. STREET ADDRESS Rt-2, Box-651						
3. NAME OF DECEASED (Type or print) Elmer JOHN W. ELMER		First	Middle	Last	4. DATE OF DEATH ENSOR August 24, 1960	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH March 2, 1886	9. AGE (In years lost birthday) 74 yrs	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS: Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Samuel Lloyd Ensor		14. MOTHER'S MAIDEN NAME Eleanor Harman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 217-01-1841		17. INFORMANT Mrs. Gertrude Ensor		Address Severna Park, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		452. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Ruptured aneurysm, st. — iliac artery arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 hrs ?		
DUE TO		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) attended the deceased from Aug. 24, 1960 to Aug. 24, 1960 that (I) last saw the deceased alive on Aug. 24, 1960, and that death occurred at 7:18 A.M. on the causes and on the date stated above.								
22. SIGNATURE Frank M. Shipley		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/24/60				
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 27, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road		25a. REC'D. BY REGISTRAR AUG 26 1960		25b. REGISTRAR'S SIGNATURE L. Frank		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 4 may be retained by the hospital or attending physician.

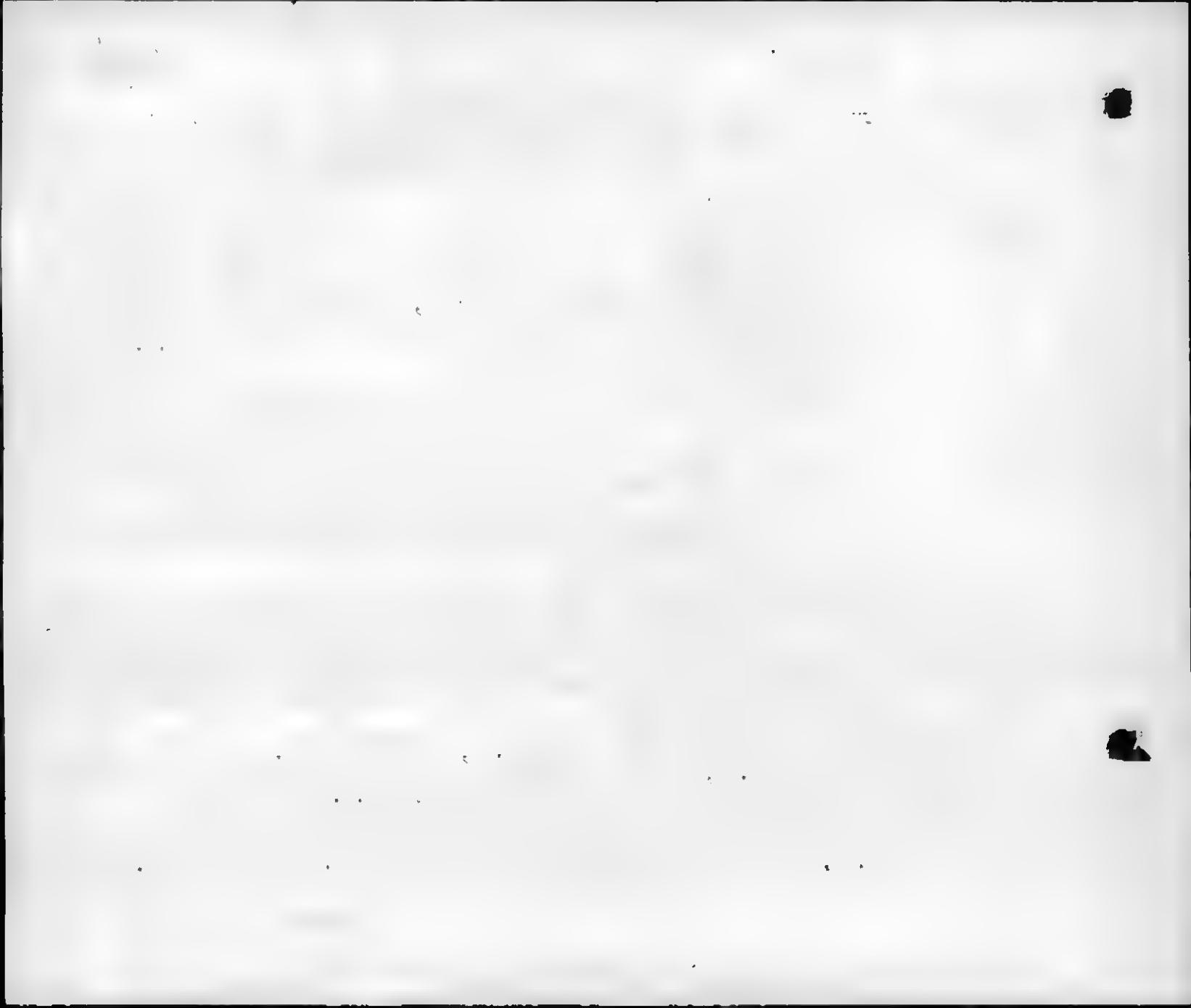
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08699

M		8703		CERTIFICATE OF DEATH		08699		
1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 9 hours		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		
						b. COUNTY Anne Arundel		
						c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RURAL - Harwood		
						d. STREET ADDRESS 		
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grace		First	Middle	Last	4. DATE OF DEATH EVANS	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1901	9. AGE (in years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Albert Hall		14. MOTHER'S MAIDEN NAME Chauncy Hall						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Grace Evans		Address Hancockville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis and arterovascular		INTERVAL BETWEEN ONSET AND DEATH				
(b)		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug. 8, 1960 , to Aug. 8, 1960 , that (I) (we) last saw the deceased alive on Aug. 8, 1960 , and that death occurred at M , from the causes and on the date stated above.								
22a. SIGNATURE A. T. Allen		22b. DATE SIGNED 11:12 A.M.						
22c. PHYSICIAN'S NAME (Type) A. T. Allen		22d. ADDRESS 62 Cathedral St., Annapolis, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial 8-12-1960		23b. DATE THEREOF Adams		23c. NAME OF CEMETERY OR CREMATORIAL Lothian Md.		23d. LOCATION (City, town, or county) (State) Lothian Md.		
24. FUNERAL DIRECTOR'S SIGNATURE William Reuse #. Anna Md.		ADDRESS 		25a. REC'D BY REGISTRAR AUG 12 '60		25b. REGISTRAR'S SIGNATURE 12-1-60		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No. 08700

8747

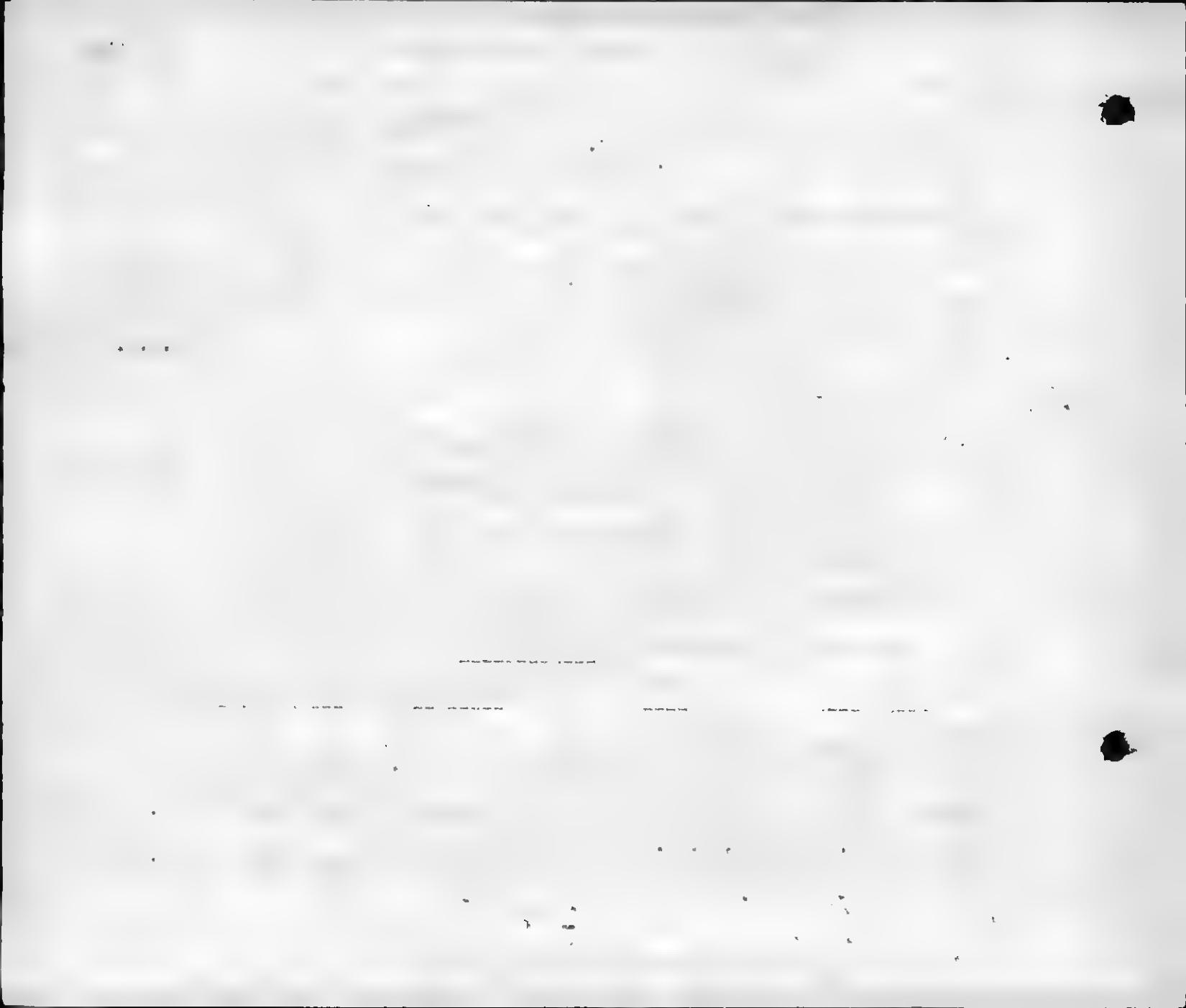
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 13 yr. 8mo. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1321 Eutaw Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle	Last Fleet	4. DATE OF DEATH	Month 8	Day 29	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 29, 1906	9. AGE (In years lost birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augusta Fleet		14. MOTHER'S MAIDEN NAME Ada Murray					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 175		Peritoneal Carcinomatosis				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Carcinoma of Ovary					
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month. Day. Year Hour ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from _____		6/3 1946		to 8/29 1960		that I last saw the deceased alive on 8/29 1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>L. Benedict, M.D.</i>		M.D.		Crownsville State Hospital, Md.		DATE SIGNED 8/30/60	
PHYSICIAN'S NAME (Type) L. Benedict, M.D.				Crownsville State Hospital, Md.		8/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-1960		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary CEM.		22d. LOCATION (City, town, or county) (State) A. A. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Milton E. Glickman</i>		ADDRESS 1129 N. Carolina St.		24a. REC'D BY REGISTRAR DATE AUG 31 '60		24b. REGISTRAR'S SIGNATURE <i>Connie L. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8711

CERTIFICATE OF DEATH

Reg. Dist. No.

08701

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>		c. LENGTH OF STAY IN lb <i>3 wks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen'l. Hosp.</i>				d. STREET ADDRESS <i>10 Virginia Ave., N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Ernest</i>	Middle <i>H.</i>	Last <i>Frank</i>	4. DATE OF DEATH <i>August 21 1960</i>	Month Year	Day 1960	Year 1960
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>24th March 1913</i>	9. AGE (In years last birthday) <i>47 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry R. Frank</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Fleagle</i>				Address <i>Glen Burnie, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-1454</i>		17. INFORMANT <i>Mrs. Ernest Frank</i>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>121 Cedarback</i>		20f. (City or town) (County) (State) <i>Glen Burnie, Md.</i>	
21. I certify that I attended the deceased from <i>2/31 1960</i> to <i>2/21 1962</i> , that I last saw the deceased alive on <i>2/21 1962</i> , and that death occurred at <i>2/21 1962</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Glen Burnie, Md.</i> DATE SIGNED <i>8/2/60</i>							
ACTUAL SIGNATURE <i>Jewell H. Dawson</i>		M.D.					
PHYSICIAN'S NAME (Type)		<i>Glenn Dawson, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>24 Aug 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Meadowridge Mem. Pk.</i>		22d. LOCATION (City, town, or county) <i>Howard Co., Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Washington</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Caroline J. Knapp</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



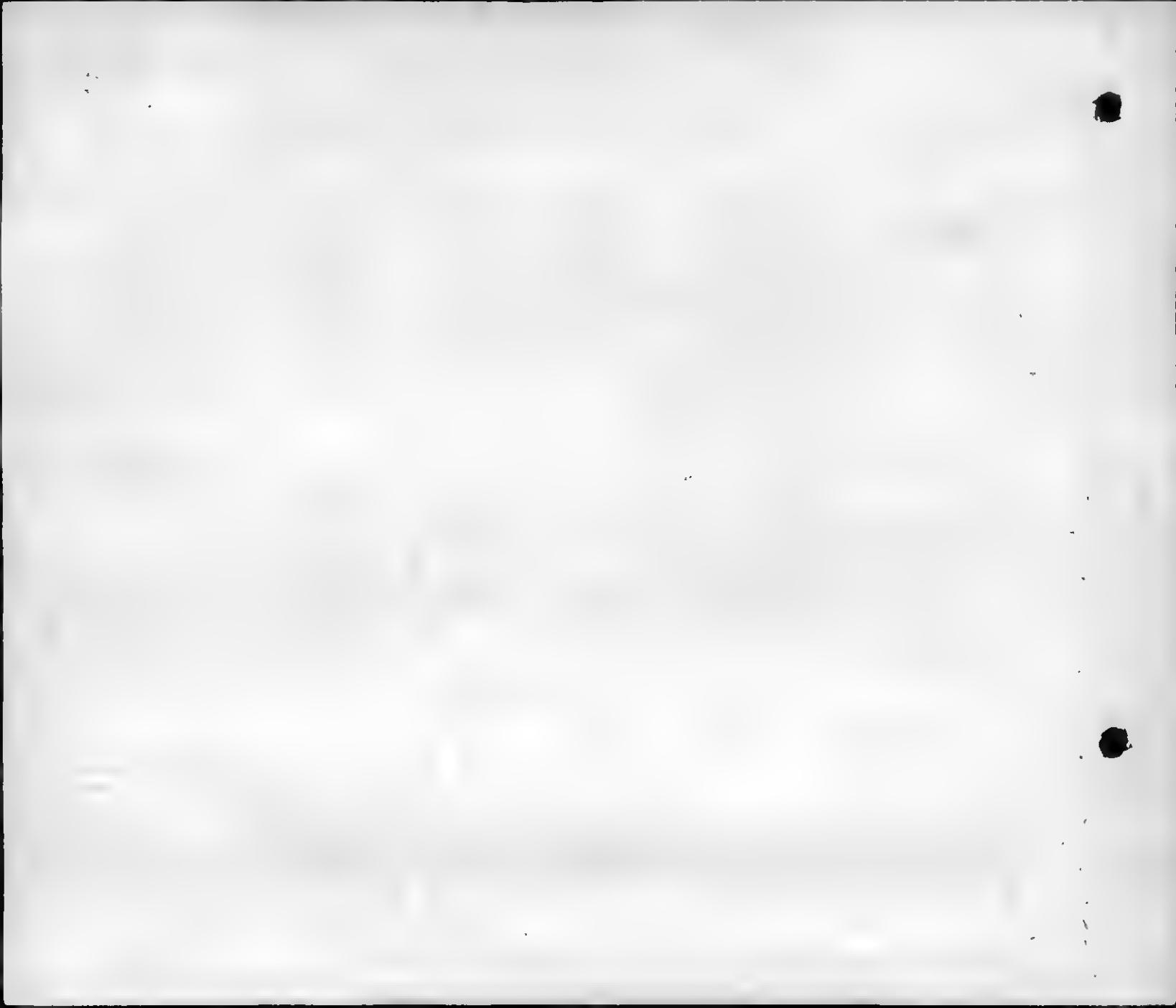
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8748

CERTIFICATE OF DEATH

Reg. Dist. No. 08702

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Beach Park</i>		c. LENGTH OF STAY IN lb <i>No</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>No</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>James Howard Fitz</i>		d. STREET ADDRESS <i>4412 Carroll St. N. W.</i>	
4. DATE OF DEATH <i>August 23 1960</i>		Month	Day
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 6, 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Navy or Marine</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Navy</i>	
13. FATHER'S NAME <i>Frederick Fitz (Retired)</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Elizabeth Fitz</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 49 <i>arterial occlusion</i>	
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Postictal May 1960</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>No</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ACTUAL SIGNATURE <i>Frank H. Wilson</i> PHYSICIAN'S NAME (Type) <i>Deputy Coroner -</i>		ADDRESS (Street, city or town, state) <i>Coltwood, Md.</i> DATE SIGNED <i>8-23-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-26-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>MT. Olivet</i>		22d. LOCATION (City, town, or county) <i>Wash. D.C.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemmons Bros.</i>		ADDRESS <i>1661 Good Hope Rd SE Wash. 20020</i>	
		24a. REC'D BY REGISTRAR <i>AUG 25 1960</i>	
		24b. REGISTRAR'S SIGNATURE <i>C. L. & K. Hause</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician until his certificate has been signed by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: A copy of this certificate should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with page 3, which should be detached for use as the burial permit. The State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08703

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 16 <i>1 year</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Baltimore City Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	
OR INSTITUTION		d. STREET ADDRESS <i>81-1000</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alvin Curtis Godden</i>		First <i>A</i>	Middle <i>lvin</i>
4. DATE OF DEATH <i>August 17 1960</i>		Month <i>Aug</i>	Day <i>17</i>
5. SEX <i>Male</i>		Year <i>1960</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13 1917</i>
9. AGE (In years last birthday) <i>62 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Husband</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fisherman</i>	
10c. BIRTHPLACE (State or foreign country) <i>England</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
12. FATHER'S NAME <i>William S. Bevens</i>		13. MOTHER'S MAIDEN NAME <i>Alma C. D. ...</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or jump down) <i>No</i>		15. SOCIAL SECURITY NO. <i>411-34-1201</i>	
16. INFORMANT <i>John Spangler</i>		17. Address <i>1315 E. Belvedere Ave., Baltimore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO <i>Cerebrovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>From falls</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>8/17/60</i> to <i>8/17/60</i> that (I) (we) last saw the deceased alive on <i>8/17/60</i> , and that death occurred <i>8/17/60</i> M, from the causes and on the date stated above		22b. DATE SIGNED <i>8/17/60</i>	
22a. SIGNATURE <i>John Spangler</i>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>John Spangler</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sidney H. Marsh</i>		22d. ADDRESS <i>1315 E. Belvedere Ave., Baltimore, Md.</i>	
23a. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Spec) <i>Burial Aug 22, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Towson Park</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sidney H. Marsh, 1315 E. Belvedere Ave., Baltimore, Md.</i>		25a. REC'D BY REGISTRAR DATE AUG 22 '60	
ADDRESS <i>1315 E. Belvedere Ave., Baltimore, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>	

جاء

فَيَقُولُونَ لِلَّهِ مَا لَمْ يَرَوْا
أَفَلَا يَرَوْنَ أَنَّا أَنْعَمْنَا بِكُمْ
مَا كُنْتُمْ تَحْسَبُونَ

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8750

CERTIFICATE OF DEATH

Reg. Dist. No.

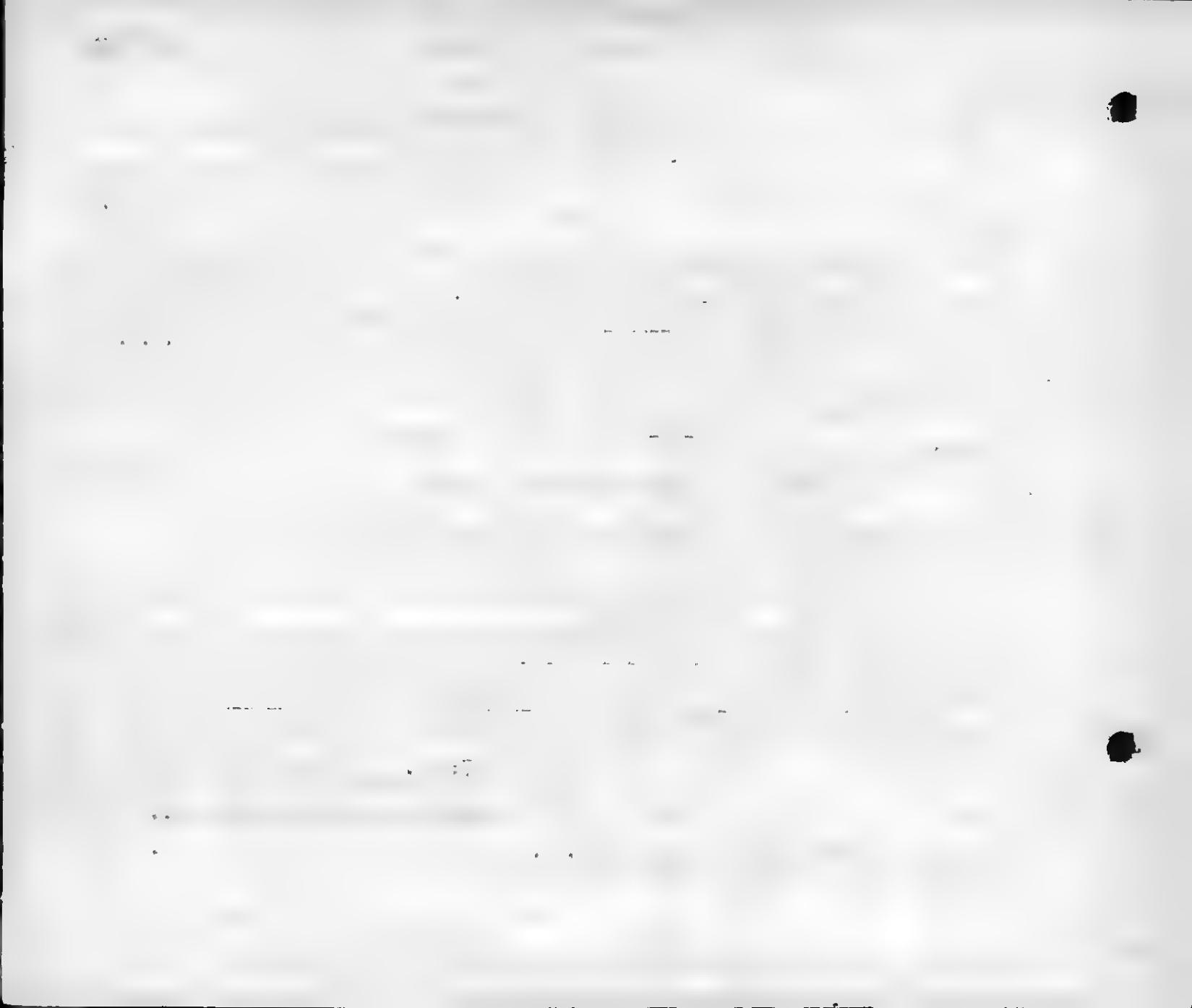
98704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS Unknown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Frank	Middle Homer	Last Gray	4. DATE OF DEATH Month 8	Day 22	Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH April 29, 1887	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Dorsey		14. MOTHER'S MAIDEN NAME Rebecca Gray						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-09-7936		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>+42X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Uremia, Decubital Ulcers DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Senility DUE TO (d) (e) (f) INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. ----- p. m. -----	Month 19	Day	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----	
21. I certify that I attended the deceased from 4/10 , 1959, to 8/22 , 1960, that I last saw the deceased alive on 8/22 , 1960, and that death occurred at 7:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 8/22/60								
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. Crownsville State Hospital, Md. 8/22/60								
PHYSICIAN'S NAME (Type)		Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md. 8/22/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/24/60	22c. Crematory Family of Patients	22d. LOCATION (City, town or county) Baltimore, Md.		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Heale 108 W. Chestnut		ADDRESS 108 W. Chestnut	24a. REC'D. BY REGISTRAR AUG 26 60	24b. REGISTRAR'S SIGNATURE James S. Knapp				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8751

CERTIFICATE OF DEATH

Reg. Dist. No.

08705

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 8 yrs. 5 mo. 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle	Last Green	4. DATE OF DEATH	Month 8	Day 3	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1886	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Green		14. MOTHER'S MAIDEN NAME Sarah ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 42d.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/6 , 19 52 , to 8/3 , 19 60 , that I last saw the deceased alive on 8/3 , 19 60 , and that death occurred at 7:30A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Benedict</i>						ADDRESS (Street, city or town, state) M.D. Crownsville State Hospital, Md. DATE SIGNED 8/3/60	
PHYSICIAN'S NAME (Type)		L. Benedict, M. D.		Crownsville State Hospital, Md.		8/3/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-8-60		22b. DATE THEREOF 8-8-60		22c. NAME OF CEMETERY OR CREMATORIUM Woodmore		22d. LOCATION (City, town, or county) Pr. Fed. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Washington</i>		ADDRESS <i>4925 Deane Lane NE</i>		24a. REC'D BY REGISTRAR DATE AUG 11 1960		24b. REGISTRAR'S SIGNATURE <i>Clinton L. Thrash</i>	



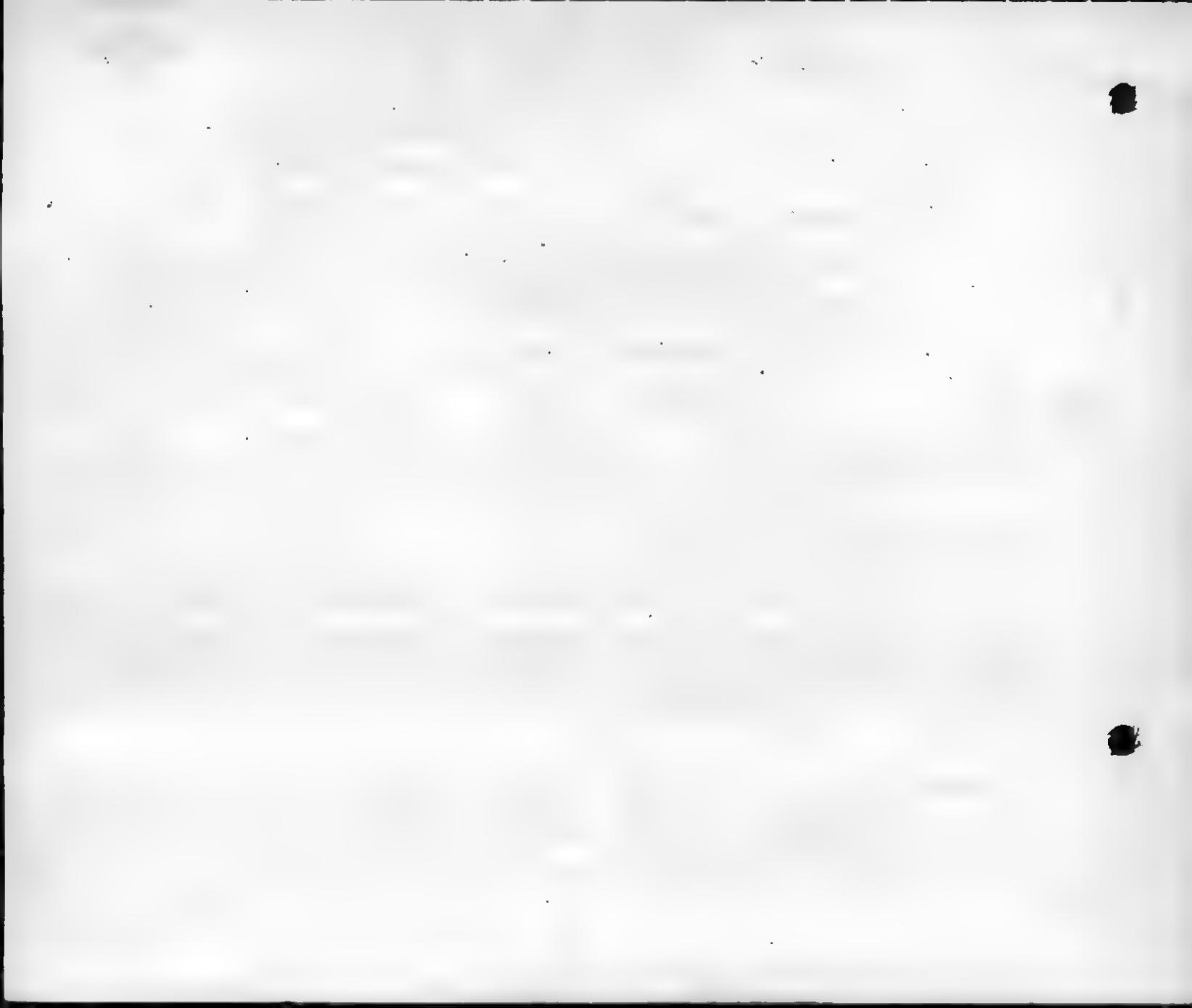


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08706

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Annapolis</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>94 Shipwright St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>94 Shipwright St</i>		e. STREET ADDRESS <i>94 Shipwright</i>	
3. NAME OF DECEASED (Type or print) <i>Louis Harwood Green</i>		First	Middle
		Lost	4. DATE OF DEATH <i>Aug 27 1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		9. DATE OF BIRTH <i>2-19-1880</i>	10. AGE (In years from birthday) <i>80 yrs</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis H. Green</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Isaac</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO <i>-</i>	17. INFORMANT <i>L. Harwood Green Jr.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Septicemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>	
DUE TO <i>Conditans, if any, which gave rise to immediate cause (a), stating the under-lying cause last.</i>		4 months.	
(b) DUE TO <i>Bed sore infection</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebro vascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>AUG 13 1960 to AUG 27 1960</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <i>121 CATHEDRAL ST</i>
(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>AUG 13 1960 to AUG 27 1960</i> , that (I) (we) last saw the deceased alive on <i>AUG 27 1960</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above		22b. DATE SIGNED <i>Aug 29 1960</i>	
22a. SIGNATURE <i>Gerard Church</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>GERARD CHURCH</i>		22d. ADDRESS <i>Annapolis Md</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 30-1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Bluff Annapolis Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jelm M. Taylor Son</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8712

CERTIFICATE OF DEATH

08707

1 PLACE OF DEATH a. COUNTY Anne Arundel		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN lb RURAL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	d. STREET ADDRESS Rt. 3, Box 709
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Wheeler	Middle B.	Last Green, Sr.
4. DATE OF DEATH Month 8	Day 14	Year 1960	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1907
9. AGE (In years last birthday) 53 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	10b. KIND OF BUSINESS OR INDUSTRY Heating & Plumbing	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Lee Green	14. MOTHER'S MAIDEN NAME Julia Barber	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)
16. SOCIAL SECURITY NO.	17. INFORMANT Doris D. Green	Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Cirrhosis of the liver, hepatic failure		INTERVAL BETWEEN ONSET AND DEATH 10 minutes ? duration	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 13 th , 1960, to Aug 14 th , 1960, that (I) (we) last saw the deceased alive on Aug 14 th , 1960, and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Church M.D.	22b. DATE SIGNED 5/26/60	MD <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 121 CATHEDRAL ST
22c. PHYSICIAN'S NAME (Type) GENERAL CHURCH			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-17-1960	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Lincoln	23d. LOCATION (City, town or county) Baltimore Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md.	25a. REC'D BY REGISTRAR DATE AUG 18 '60	25b. REGISTRAR'S SIGNATURE C. L. S. Thomas	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8752

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08708

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hillersville

MARYLAND

c. LENGTH OF STAY IN lb

6 Y.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Box 139

First

Middle

Last

3. NAME OF
DECEASED
(Type or print)

Benjamin Wallington Guinn

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

11/12/10

4. DATE
OF
DEATH

Month Day Year

AUGUST 20th 1960

IF UNDER 1 YEAR | IF UNDER 24 HRS.

48 yrs. Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10b. KND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dickson City Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward ~~Guinn~~ Guinn

14. MOTHER'S MAIDEN NAME

Anna Hall

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give record of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Ruby Guinn

INTERVAL BETWEEN
ONSET AND DEATH
4 yrs.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute posterior occlusion, myocardial infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE:

EXAMINER'S
NAME (Type)

Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

8/22/60

Address (Street, city, town, or county)

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22d. LOCATION (City, town, or country)

Burial 8/24/60

Glen Haven Mem. Park

Glen Burnie, Md.

23. FUNERAL DIRECTOR

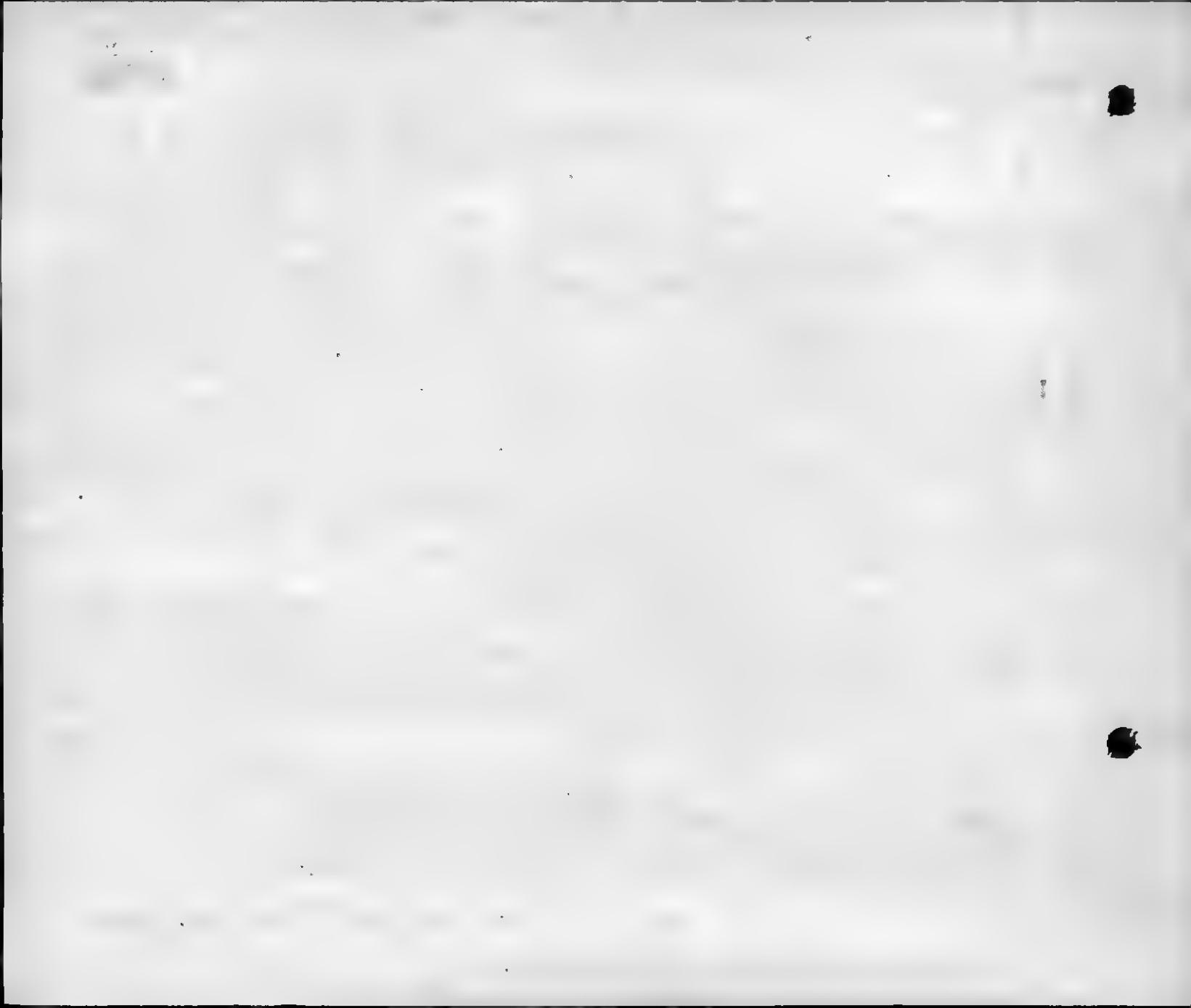
J. Kirkley ADDRESS

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Hopping and Kirkley, Glen Burnie, Md.

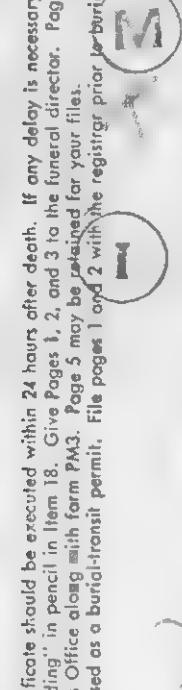
DATE AUG 23 '60

I. Krause



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08709
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kate Knapp</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dorsey Rd #176, 100 ft. W. Harman Expressway</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dorsey Rd #176, 100 ft. W. Harman Expressway</i>		e. STREET ADDRESS <i>Box 112 C Dorsey Rd</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Rufus</i>		4. DATE OF DEATH <i>8/27/1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>CA</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1915</i>
9. AGE IN YEARS <i>45 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>W. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>W. Md.</i>	
13. FATHER'S NAME <i>John Knapp</i>		14. MOTHER'S MAIDEN NAME <i>Ethel Hall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>William N. Hall 1944 Ridgefield Pa</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive facial skull fractures</i> DUE TO <i>3702</i> Conditions, if any, which gave rise to immediate cause (b) DUE TO <i>cause lost.</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Apparantly hit-run</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Apparantly hit-run</i>	
20c. TIME OF INJURY Month, Day, Year <i>9:15 p.m. 8/27/60</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W. Bradley King Jr. MD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>8/28/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/31/1960</i>	
22c. NAME OF CEMETERY OR CEMATORIUM <i>Saints Rest Cemetery</i>		22d. LOCATION (City, town, or county) <i>Harmons Hill</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Miss Edie L. Mission</i>		24a. REC'D BY REGISTRAR <i>Date 8/28/60</i>	
ADDRESS <i>322 N. Charles St.</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Knapp</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

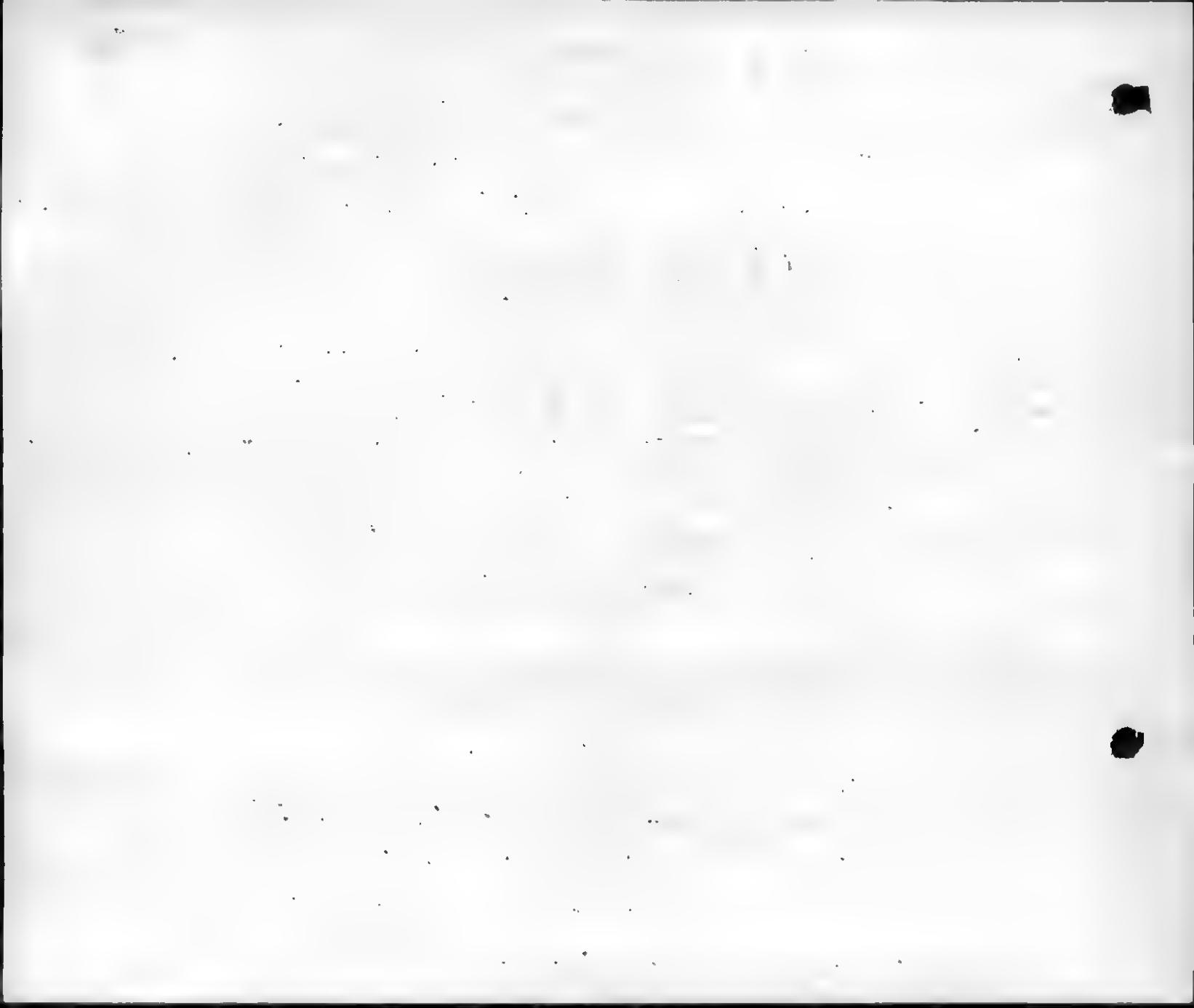
CERTIFICATE OF DEATH

08710

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: At this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) b. STATE Maryland COUNTY W.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION Ft. 1 Bay 146		d. STREET ADDRESS Ft. 1 Bay 146	
3. NAME OF DECEASED (Type or print) William		4. DATE OF DEATH Last 4-21 Month 8 Day 11 Year 1960	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male COLOR OR RACE Col		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH 4-2-1881		8. AGE (In years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Hall		14. MOTHER'S MAID NAME Rachel Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 28-12-44024 INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hyperkinetic Cardio-Vascular Disease (c) DUE TO General Atrophy		INTERVAL BETWEEN ONSET AND DEATH 24 hr. 10 yrs 10 yrs.	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS ALCOHOL PERFUSED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11/1960 to 8/11/1960, that I last saw the deceased alive on 8/11/1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) THEODORE H. JOHNSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-60	
22c. NAME OF CEMETERY OR CREMATORIAL Fowlers		22d. LOCATION (City, town, or county) Best Gate	
23. FUNERAL DIRECTOR'S SIGNATURE William Beese, Jr.—Annap. Md.		24a. REC'D BY REGISTRAR AUG 17 1960	
ADDRESS		24b. REGISTRAR'S SIGNATURE G. E. L. & H. M.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08511

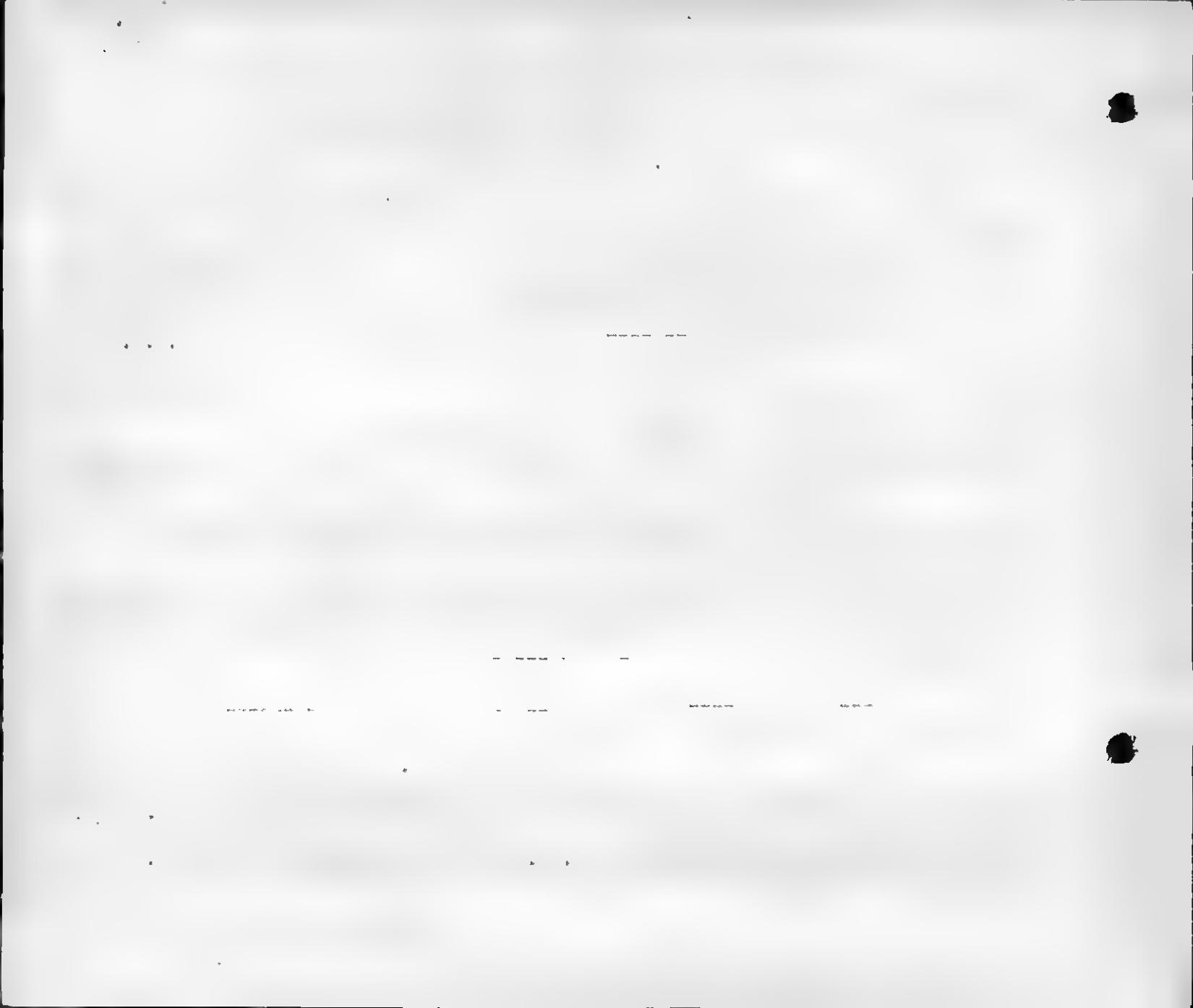
Reg. Dist. No.

8755

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 2316 Hunter Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lizzie		First	Middle	Lost	4. DATE OF DEATH Hampton	Month 8	Day 15	Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881?	9. AGE (In years less birthday) 79? yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 79	Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----									
20c. TIME OF INJURY Hour o. m. --- p. m. 19	Doy.	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County)	(State)				
21. I certify that I attended the deceased from alive on 8/15 , 19 60		and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) -----									
ACTUAL SIGNATURE <i>Hildegard Heard Reissmann</i>	DATE SIGNED 8/16/60										
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.	Crownsville State Hospital, Md. 8/16/60										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/22/60	22c. NUMBER 100		22d. LOCATION (City, town or county) Town of Sparrow Field, Md.		(State) -----					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Max Kress</i>	ADDRESS 118 W. West	24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knave</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

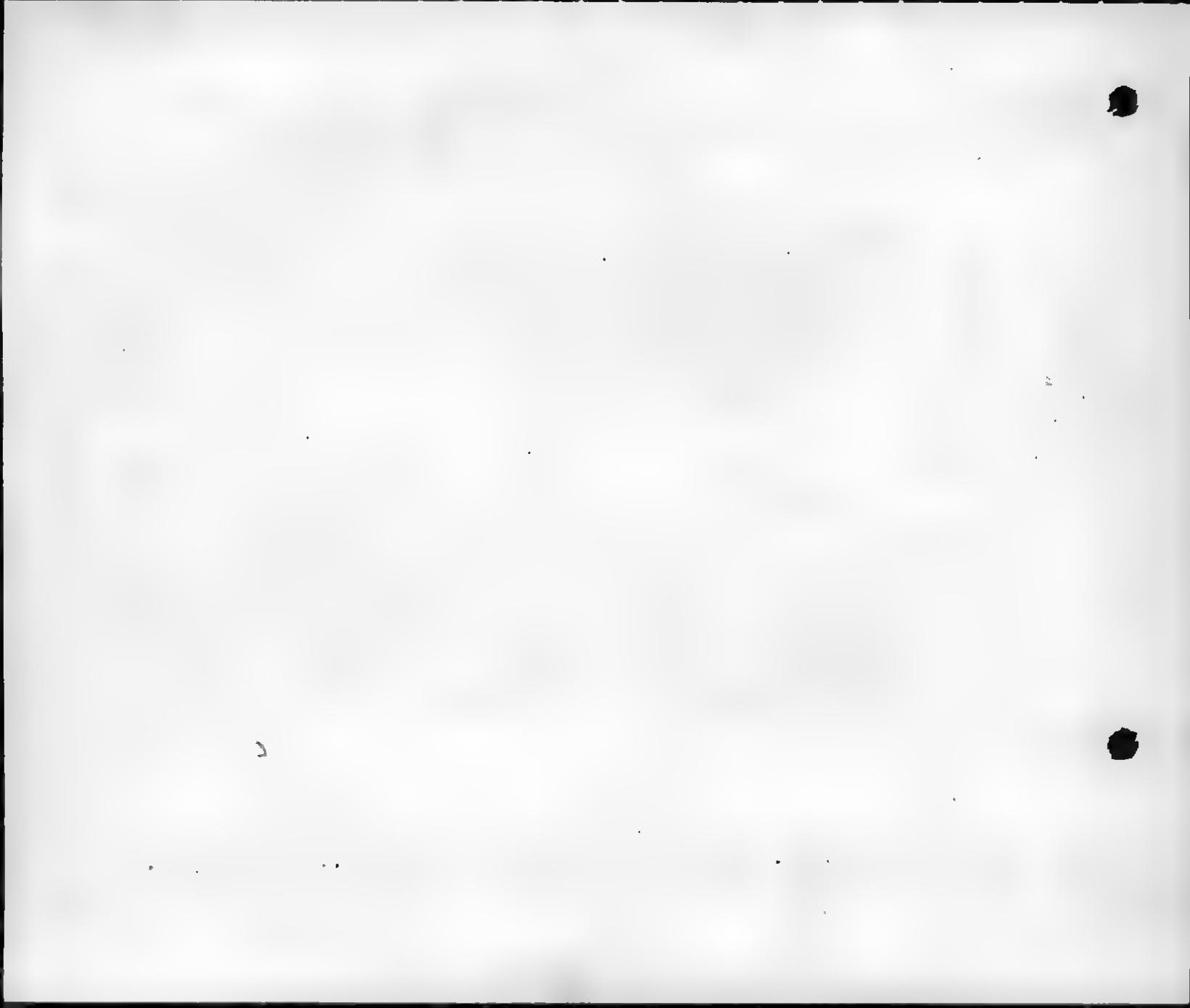
08712

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8756

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>By Water Road</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>By Water Road.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Amesbury Md 09.7L.</i>		d. STREET ADDRESS <i>Annapolis M.R.F.D.</i>	
3. NAME OF DECEASED (Type or print) <i>William Preston HARRISON Sr</i>		First <i>William</i>	Middle <i>Preston</i>
		Last <i>HARRISON Sr</i>	4. DATE OF DEATH <i>Aug 30 1960</i>
S. SEX <i>Male</i>	COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 25-1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	11. BIRTHPLACE (State or foreign country) <i>Calvert Co Md</i>
13. FATHER'S NAME <i>William Henry HARRISON</i>		14. MOTHER'S MAIDEN NAME <i>SARAH ELIZABETH Watson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO <i>—</i>	17. INFORMANT <i>GRACE S. HARRISON #2</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROSIS</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>10 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>HYPERTENSIVE HEART DISEASE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/22 1960</i> to <i>8/30 1960</i> , that (I) (we) last saw the deceased alive on <i>8/26 1960</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Edward S. Beck</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>8/31/60</i>
22c. PHYSICIAN'S NAME (Type) <i>Edward S. BECK</i>		22d. ADDRESS <i>71 Franklin St., Annapolis, Md.</i>	
23a. BURIAL, Cremation, Removal (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 2 - 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemt</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	25a. REC'D BY REGISTRAR DATE SEP 2 '60
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08713

1. PLACE OF DEATH

b. COUNTY

Anne Arundel

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Glen Burnie

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

413 Magnolia Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

LILLIAN

G.

HOLLINS

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

7/11/89

Last

4

DATE
OF
DEATH

August 30th

71

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

19 60

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRT ACE (State or foreign country)

baltimore

12. C.TIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Alkers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mr Harry S. Wright - 413 Magnolia Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

23. FUNERAL DIRECTOR

Burial 9/2/60

Lawn J. Pickering & Sons - Balto

ADDRESS

Loudon Park Com.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

8/30/60

Address (Street, city, town or county)

22d. LOCATION (City, town, or country)

(State)

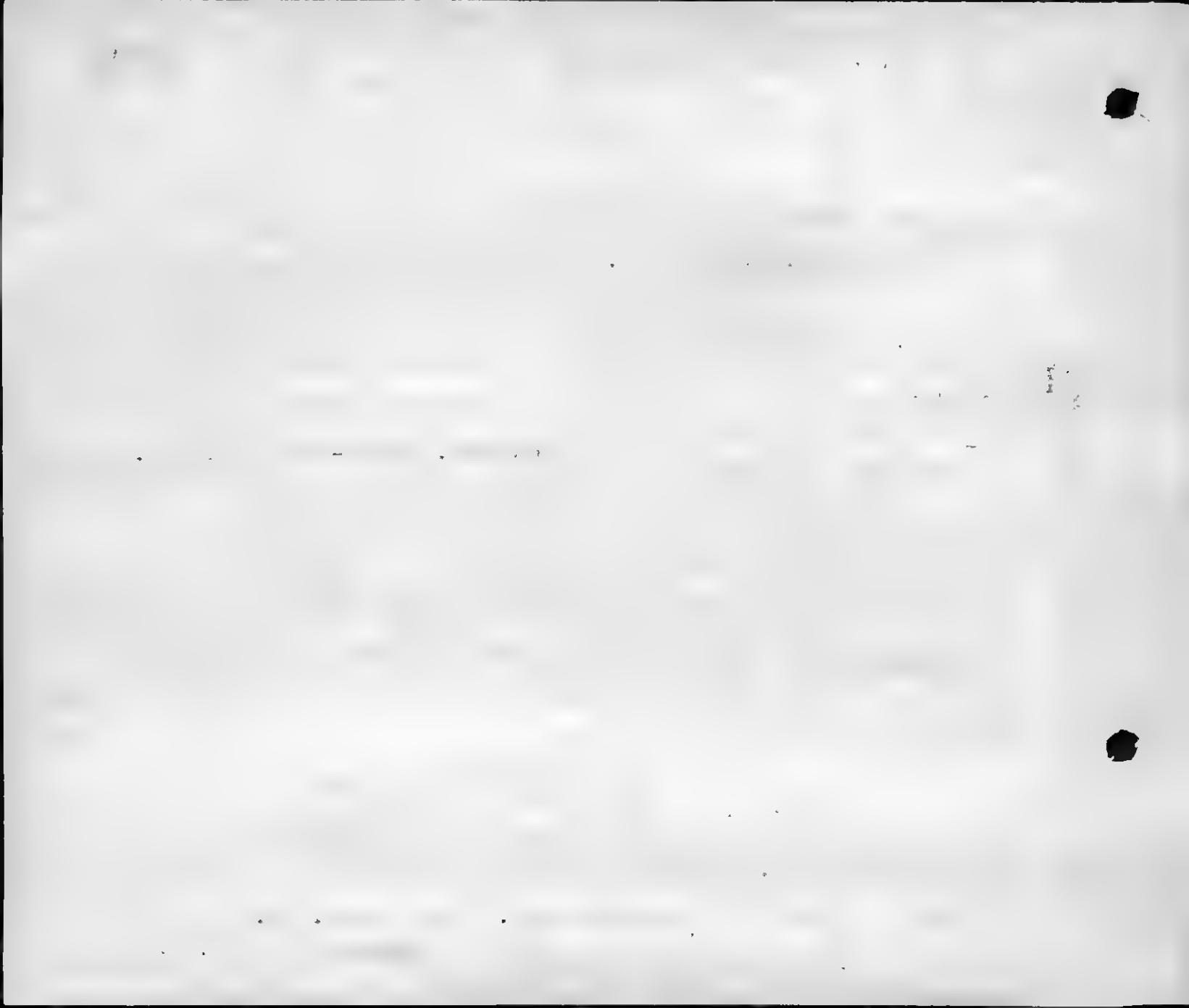
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE AUG 31 '60

Loring S. Thomas

17 Med



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

8758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08714

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

b. CITY OR TOWN [if outside corporate limits, write RURAL and give nearest town]

Fort Meade

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Donohue Lasebal Field

3. NAME OF
DECEASED
(Type or print)

5. SEX

Paul I. Honor, III

6. COLOR OR RACE

H W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

1/19/32

9. AGE (in years) IF UNDER 1 YEAR
day birthday months days hours min.

20 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Civil Service

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

13. FATHER'S NAME

Paul I. Honor Jr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) If yes give rank or date of service)

YES ROMAN

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Mrs. Mary C. Friedrichs (Mother)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Electrocution

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), showing the underlying

cause less.

(b)

DUE TO

(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e. 19. WAS AUTOPSY
PERFORMED?YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

Apparently touched (live) wire while on light pole

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

9:50 AM 8/22 1960

20d. INJURY OCCURRED While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Baseball Field

20f. (City or town)

(County)

(State)

Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opiniondeath resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER

M.D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

Glen Burnie, Md.

DATE SIGNED

8/23/60

VS. A15ME

SM 7/59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

Pvt. Crem. 1960

22b. DATE THEREOF

Arlington Nat'l. Cem.

ADDRESS

Glen Burnie, Md.

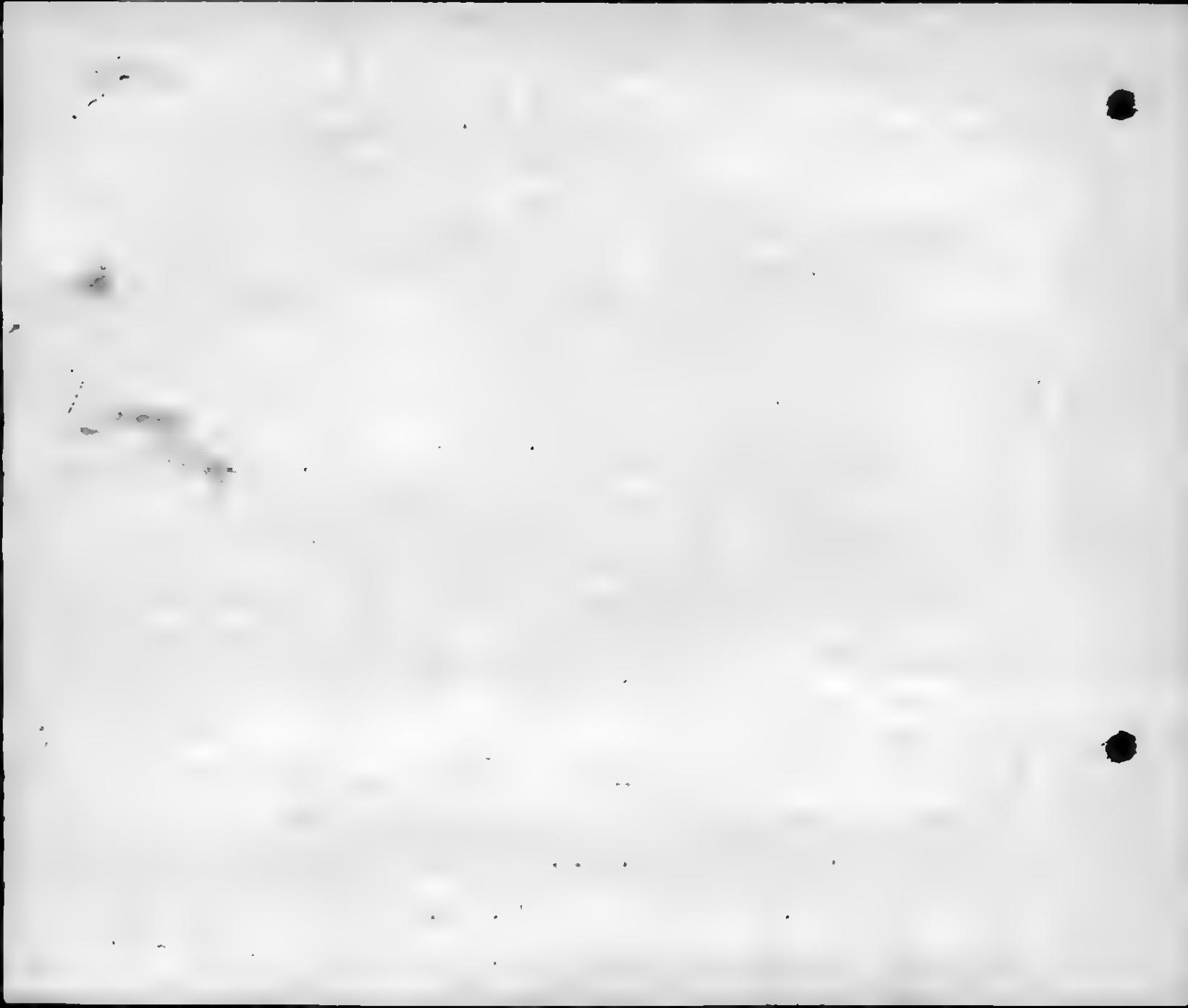
24a. REC'D BY REG STAR (24b. REGISTRAR'S SIGNATURE)

AUG 26 '60

DATE

James S. Thomas

Signature



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08715

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 10th

1 hour

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel

3. NAME OF
DECEASED
(Type or print)

First
Robert E.

4. SEX
Male

6. COLOR OR RACE
W

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Hone

13. FATHER'S NAME

Tobie

Ingle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

154.5 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last

Cardiac arrest

Congenital heart disease c
congestive heart failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN
ONSET AND DEATH
immediate

3 weeks

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion
death resulted from Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Willard F. Smith

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
8/1/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

8-3-60

22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS

Western Cemetery

22d. LOCATION (City, town, or country)
Bal. + 14th St., N.C.

(State)

23. FUNERAL DIRECTOR

McCullough Funeral Home 130 E First Street
ADDRESS: 22 N.W. DAT AUG 4 '60
Cultus & Sons

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59
Hours



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. A copy of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

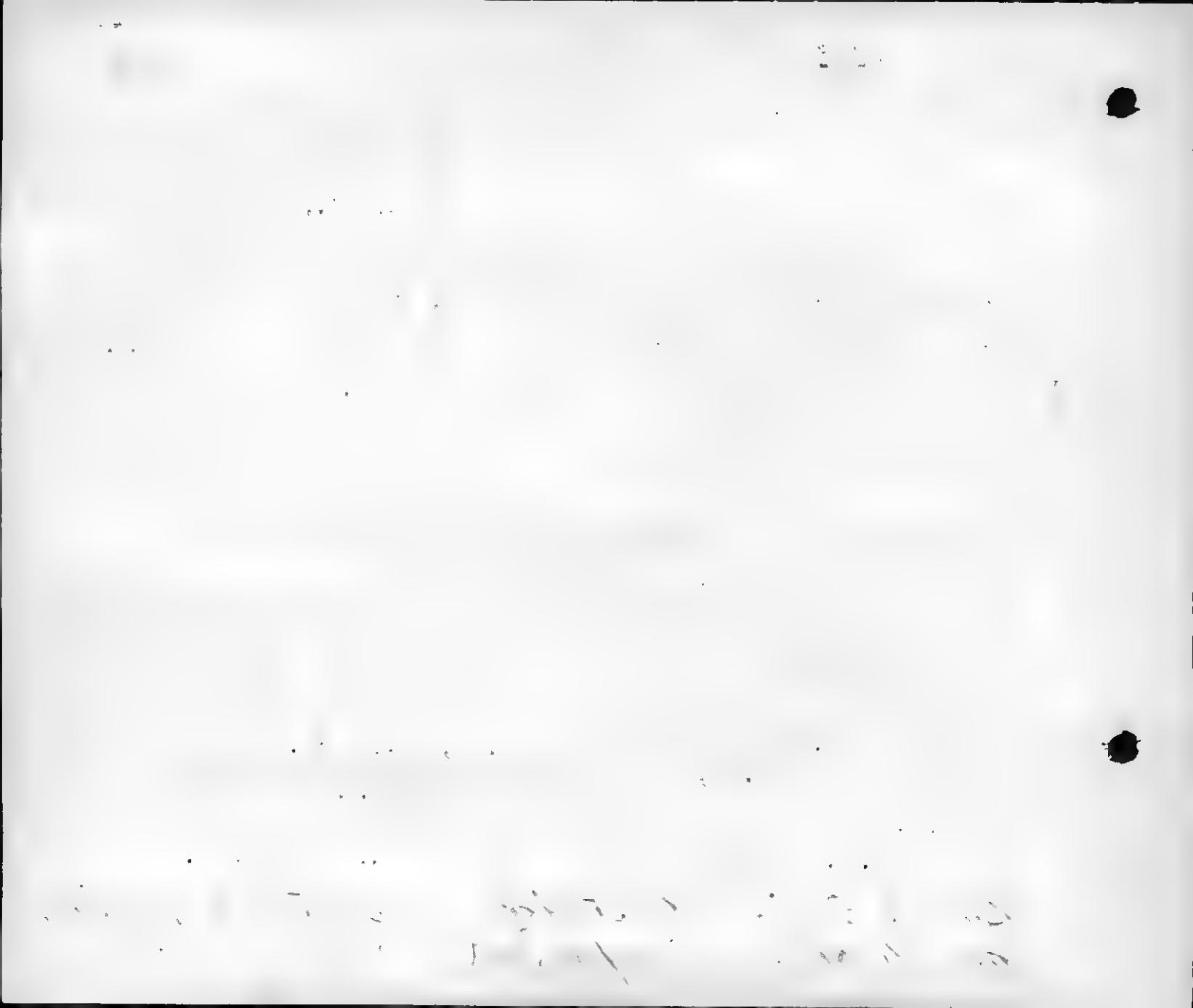
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8714

08716

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	b. COUNTY Anne Arundel
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 25 West St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora	First	Middle	Last JACKSON
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1926
9. AGE (in years from last birthday) 34	10. INDUSTRY Kitchen supervisor	11. BIRTHPLACE (State or foreign country) Alabama	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Edward	14. MOTHER'S MAIDEN NAME Mammie L. Edward		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No	16. SOCIAL SECURITY NO. 112-2-1234	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Giant Pulmonary Edema DUE TO 645.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Exanguination DUE TO (c) Refractory End stage Pregnancy DUE TO 1 Month INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) R. L. Richardson attended the deceased from Aug. 22, 1960 to Aug. 30, 1960 , that (I) NO last saw the deceased alive on Aug. 30, 1960 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE R. L. Richardson		22b. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS 110 Clay St., Annapolis, Md.			
23a. BURIAL, CREMATION REMOVAL Specified Burial	23b. DATE THEREOF 9-5-60	23c. NAME OF CEMETERY OR CREMATORIAL Prestwick	23d. LOCATION (City, town or county) Prestwick, Alas.
24. FUNERAL DIRECTOR'S SIGNATURE James H. Johnson, Annapolis, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE Aug. 31, 1960	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be filed as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S {4}
15M 9/59

1. PLACE OF DEATH a. COUNTY Anne Arundel			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Battle Creek			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Battle Creek			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital			d. STREET ADDRESS 513 Jackson			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH C JACKSON JR.			First JOSEPH	Middle C	Last JACKSON JR.	4. DATE OF DEATH August 16 1960	Month August	Day 16	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1933			9. AGE (In years last birthday) 27 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY U.S. Army			11. BIRTHPLACE (State or foreign country) Chicago, Ill			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Joseph Jackson			14. MOTHER'S MAIDEN NAME Bessie Racklin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO 374-34-0902			17. INFORMANT Personnel Records Ft Geo G. Meade, Md.			
						Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septisemia						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			Infected stab wound of chest			5 days			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Blood disorder			Sickle Cell disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) Stated he fell on piece of glass						
20c. TIME OF INJURY Month, Day, Year Hour o. m. Aug 11 60 p. m. Unknown 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown			
20f. (City or town) Unknown			(County)			(State)			
21. I certify that I saw the deceased alive on 11:00PM 15 Aug 60 , and that death occurred at 02:30 A from the causes and on the date stated above									
22a. SIGNATURE Stanley Siegelman									
22b. DATE SIGNED 16 Aug 60									
22c. PHYSICIAN'S NAME (Type) STANLEY S. SIEGELMAN, Capt., M.C.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. ADDRESS USA Hosp Ft Geo G. Meade, Md.			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/18/60			23c. NAME OF CEMETERY OR CREMATORIAL Robins Funeral Home Bloomington, Ill.			
23d. LOCATION (City, town, or county) Bloomington, Ill.						(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Stanley Siegelman, Capt., M.C.			ADDRESS 111 W. Monroe St., Suite 1000, Chicago, Ill.			25a. REC'D BY REGISTRAR DATE AUG 19 '60			
						25b. REGISTRAR'S SIGNATURE John S. Ryan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8760

CERTIFICATE OF DEATH

08718

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 yrs. 7 mo. 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,		d. STREET ADDRESS 208 Clay Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Roger	Last Johnson	4. DATE OF DEATH	Month 8	Day 10	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1887	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrison Johnson				14. MOTHER'S MAIDEN NAME Cecelia Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO War I		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic Cardiovascular Disease							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
DUE TO (b) Arteriosclerotic Cardiovascular Disease		DUE TO (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour a. m. p. m. -----	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from 4/23 , 19 47 , to 8/10 , 19 60 , that I last saw the deceased alive on 8/10 , 19 60 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE L. Benedict, M. D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-60		22c. NAME OF CEMETERY OR CREMATORIUM Time Lawn		22d. LOCATION (City, town, or County) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reed, Jr.		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8761

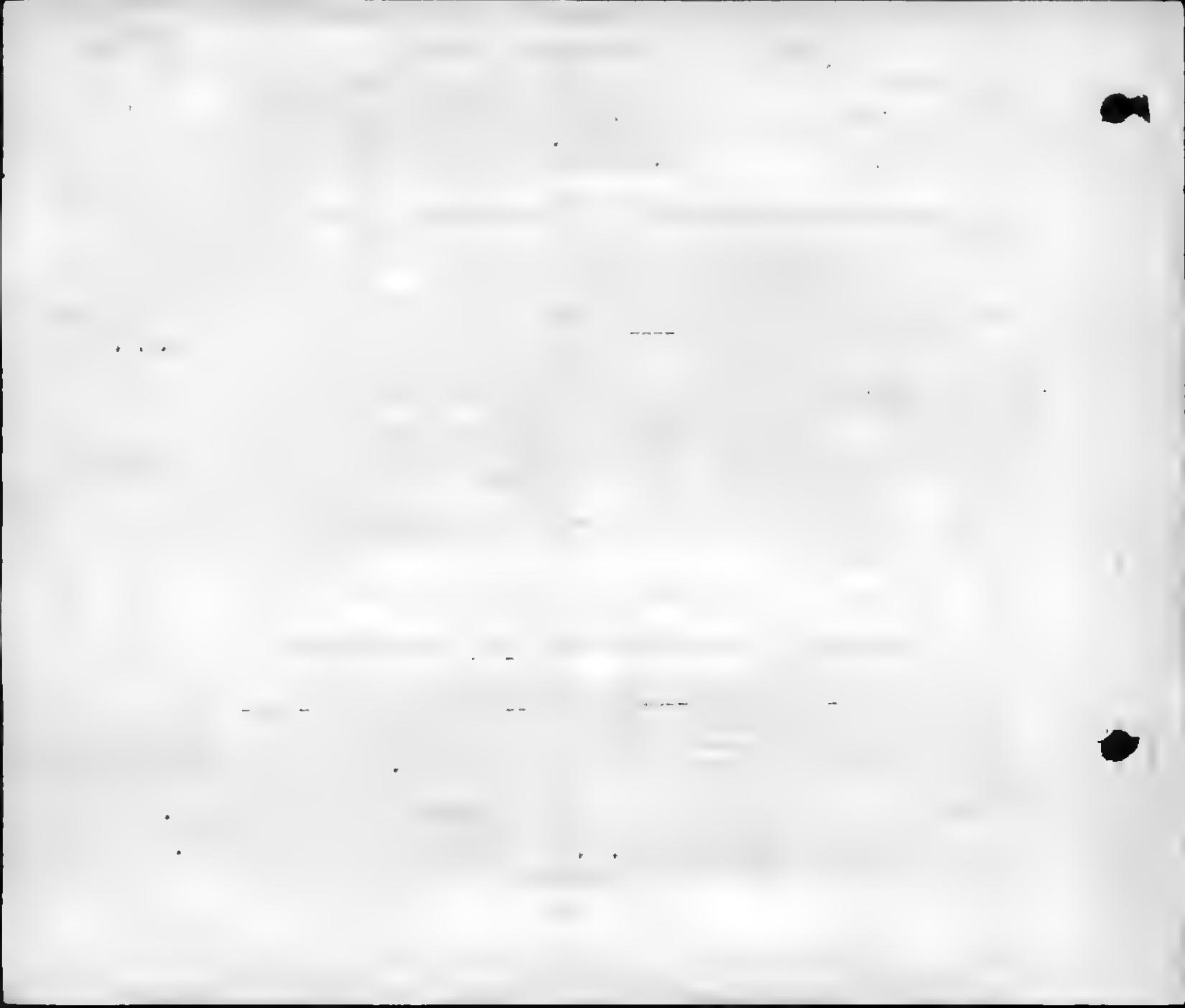
CERTIFICATE OF DEATH

Reg. Dist. No.

08719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be
 the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 11 years 4 mo. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vista					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		168-7			
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Leo	Last Jones	4. DATE OF DEATH	Month 8	Day 29	Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH December 18, 1918	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Jones			14. MOTHER'S MAIDEN NAME Mary Brown			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a m p. m	Month ----- 19	Day -----	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----		
21. I certify that I attended the deceased from 12/9 , 1946, to 8/29/ 1960, that I last saw the deceased alive on 8/29 , 1960, and that death occurred at 9:28 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.								DATE SIGNED 8/30/60	
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	M.D. Crownsville State Hospital, Md.								
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	Crownsville State Hospital, Md.							8/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/2/60	22c. NAME OF CEMETERY OR CREMATORIUM Univ. of Md.	22d. LOCATION (City, town, or county) Baltimore Md.		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE William Reese II		ADDRESS 18th & Washington Springfield, Md.	24a. REC'D BY REGISTRAR DATE SEP 6	24b. REGISTRAR'S SIGNATURE K. K. K.					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08720

8762

CERTIFICATE OF DEATH

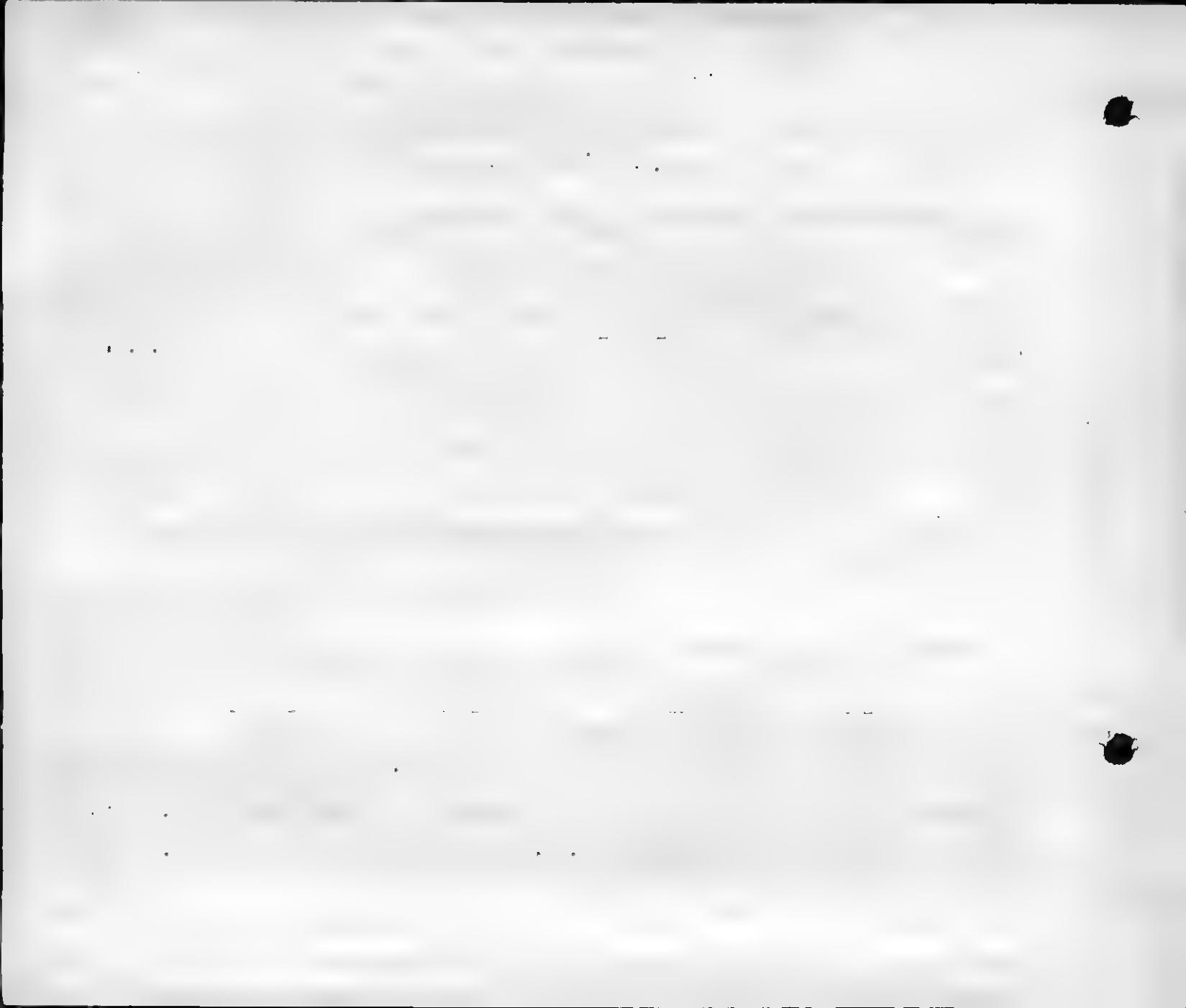
Reg. Dist. No.

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: As this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 29 yrs. 4 mo. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Joseph	Middle	Last Jones	4. DATE OF DEATH	Month 8	Doy 6	Year 1960	
5. SEX	6. COLOR OR RACE Male Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Ada ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. War #1		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 44-3X (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) -----						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY	Month	Doy	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour p. m	-----	19						
21. I certify that I attended the deceased from 3/7 , 19 31 , to 8/6 , 19 60 , that I last saw the deceased alive on 8/6 , 19 60 , and that death occurred at 1:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Hildegard Heard Reissmann</i> M.D. Crownsville State Hospital, Md. 8/8/60 DATE SIGNED 8/8/60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-11-60		22b. DATE THEREOF 8-11-60	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY ARLINGTON VA		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN TRHINES		ADDRESS 3015 12th St. N.W.	24a. REC'D BY REGISTRAR AUG 12 '60		24b. REGISTRAR'S SIGNATURE John E. K. Brown			

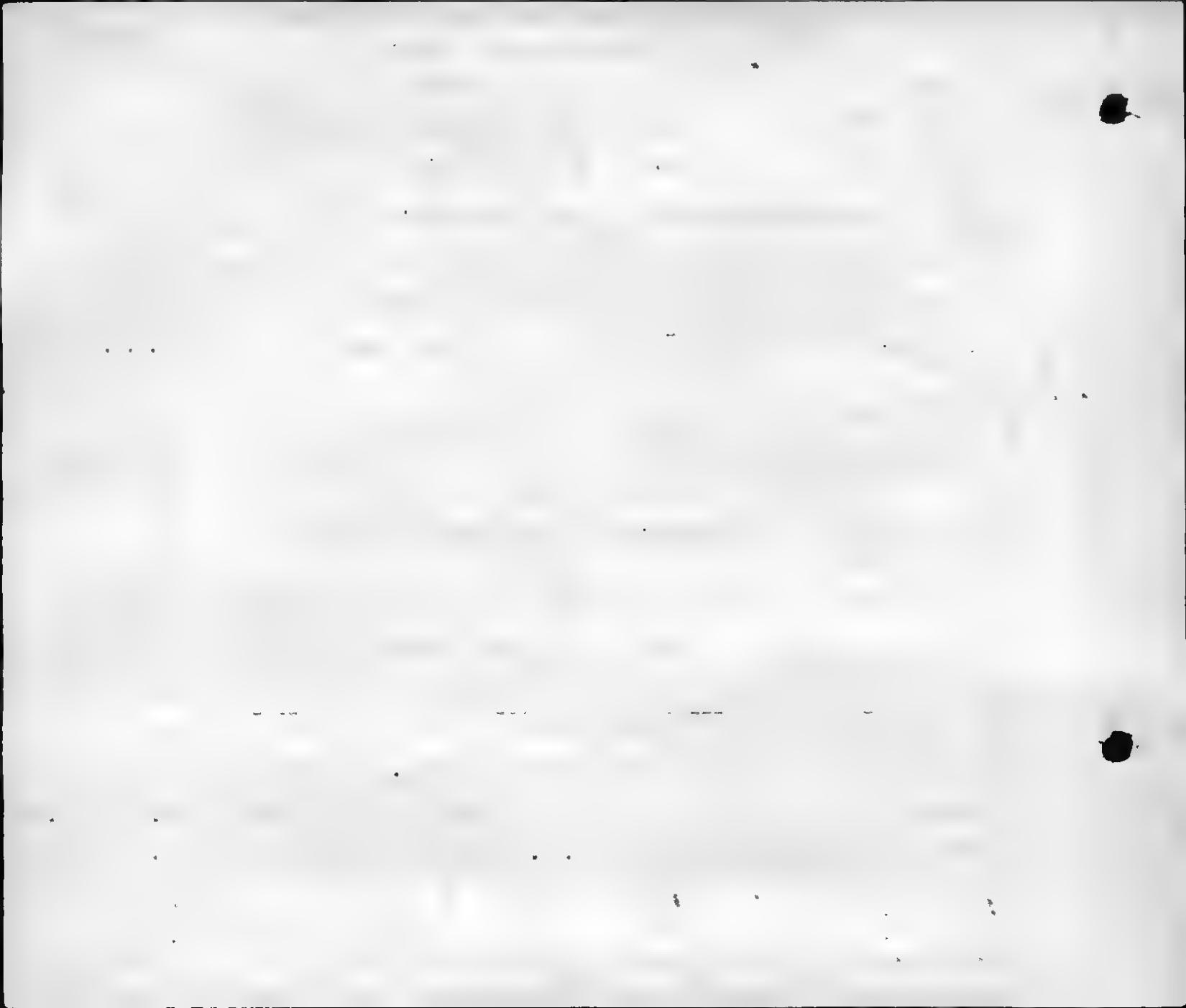


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8763 CERTIFICATE OF DEATH

Reg. Dist. No.

08721

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6mo. 9 years 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Route 14, Box 632		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Maxwell	Middle Major	Last Jones	4. DATE OF DEATH 8 28 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Hour o. m. p. m. ----- 19	Month -----	Day -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from 2/27 , 19 51 , to 8/28 , 19 60 , that I last saw the deceased alive on 8/28 , 19 60 , and that death occurred at 4:14 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 8/29/60							
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. CROWNSVILLE STATE HOSPITAL, MD. 8/29/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-1-1960	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SHARP STREET CEM. CHASE, Md.	22d. LOCATION (City, town, or county) -----	(State) -----			
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Lichten		24a. REC'D BY REGISTRAR DATE AUG 31 '60	24b. REGISTRAR'S SIGNATURE L. Milton E. Lichten				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached to use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8715

CERTIFICATE OF DEATH

08722

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS 600 6th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sarah	Middle <i>Catterton</i>	Last JONES
4. DATE OF DEATH	Month August	Day 3	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1894
9. AGE (In years last birthday) 66 yrs	10. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME <i>Eugene Catterton</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown.) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <i>Mrs Stewart Leitch</i>	Address <i>(2)</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 392X DUE TO CEREBRAL THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (c) ARTERIOSCLEROTIC HEART DISEASE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18) While at work		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 31, 1960 to Aug. 3, 1960 , that (I) <input type="checkbox"/> last saw the deceased alive on Aug. 3, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Beck</i>	M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 8/4/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck	22d. ADDRESS 71 Franklin St., Annapolis, Md.		
23a. FUNERAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-6-1960	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery	23d. LOCATION (City, town, or county) Mt. Zion, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>	ADDRESS <i>Annapolis, Md.</i>	25a. REC'D BY REGISTRAR Curtis S. Tracy	25b. REGISTRAR'S SIGNATURE <i>Curtis S. Tracy</i>
DATE AUG 8 '60			

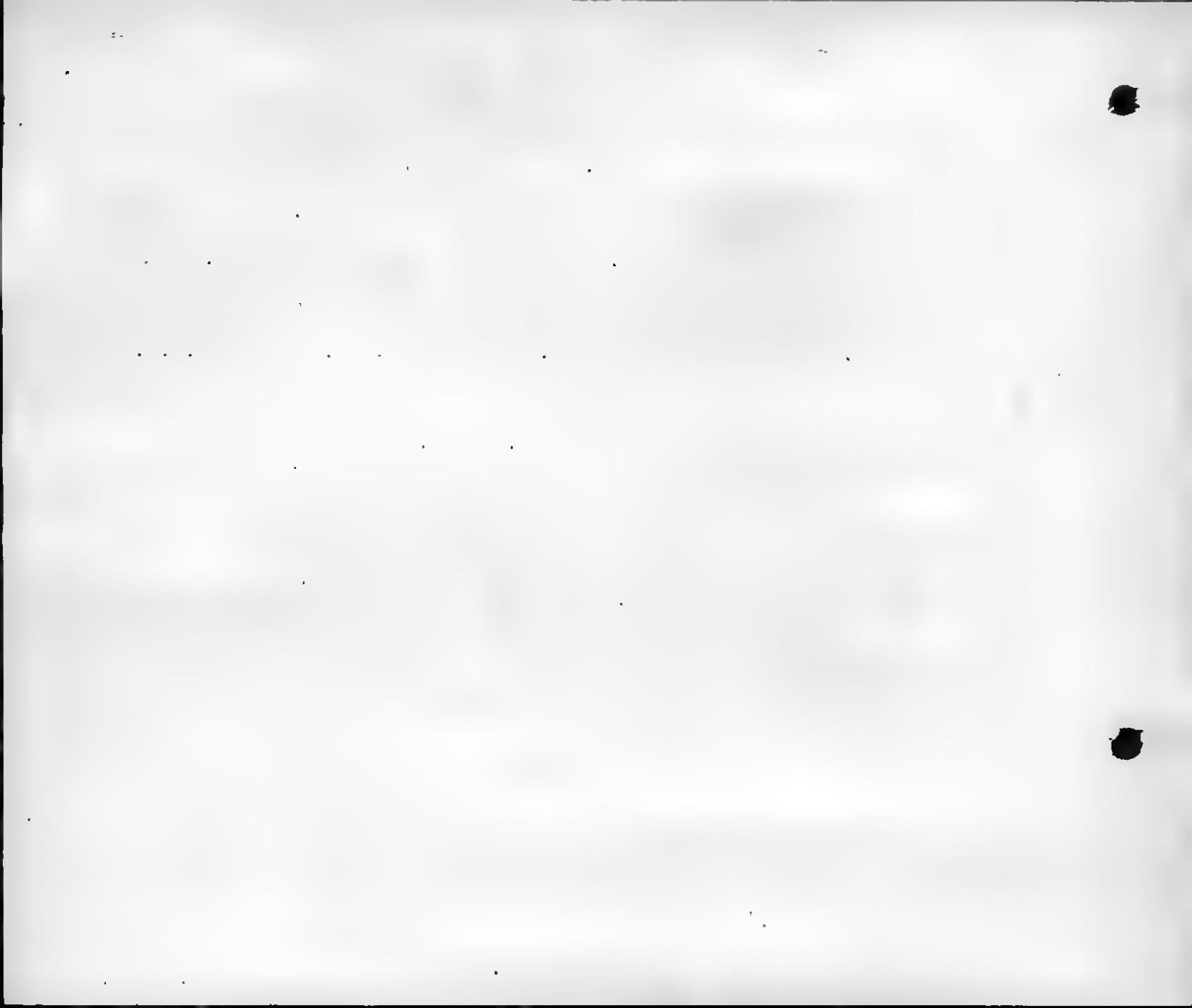


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8764 CERTIFICATE OF DEATH

08723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #435 Cleveland Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM D. JOYNES		First Middle Last	4. DATE OF DEATH Aug. 18, 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7th July 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Keystone Elec Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Joynes		14. MOTHER'S MAIDEN NAME Ida (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT Mrs. Ada B. Joynes	Address Somr. A-#2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO		Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 days	
(b) DUE TO		Arteriosclerosis 10-12 yrs	
(c) DUE TO		Ca of Prostate + Bleeding 3-4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 8/18/60, 19____, and that death occurred at 5:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Chas. E. Ball Jr. M.D. ADDRESS (Street, city or town, state) Physician's Name (Type) Linthicum Md. DATE SIGNED 8/19/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 20th Aug. 1960	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Singletary		24e. RECEIVED BY REGISTRAR DATE 8/22/60	24f. REGISTRAR'S SIGNATURE Charles S. Krause
ADDRESS Glen Burnie, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

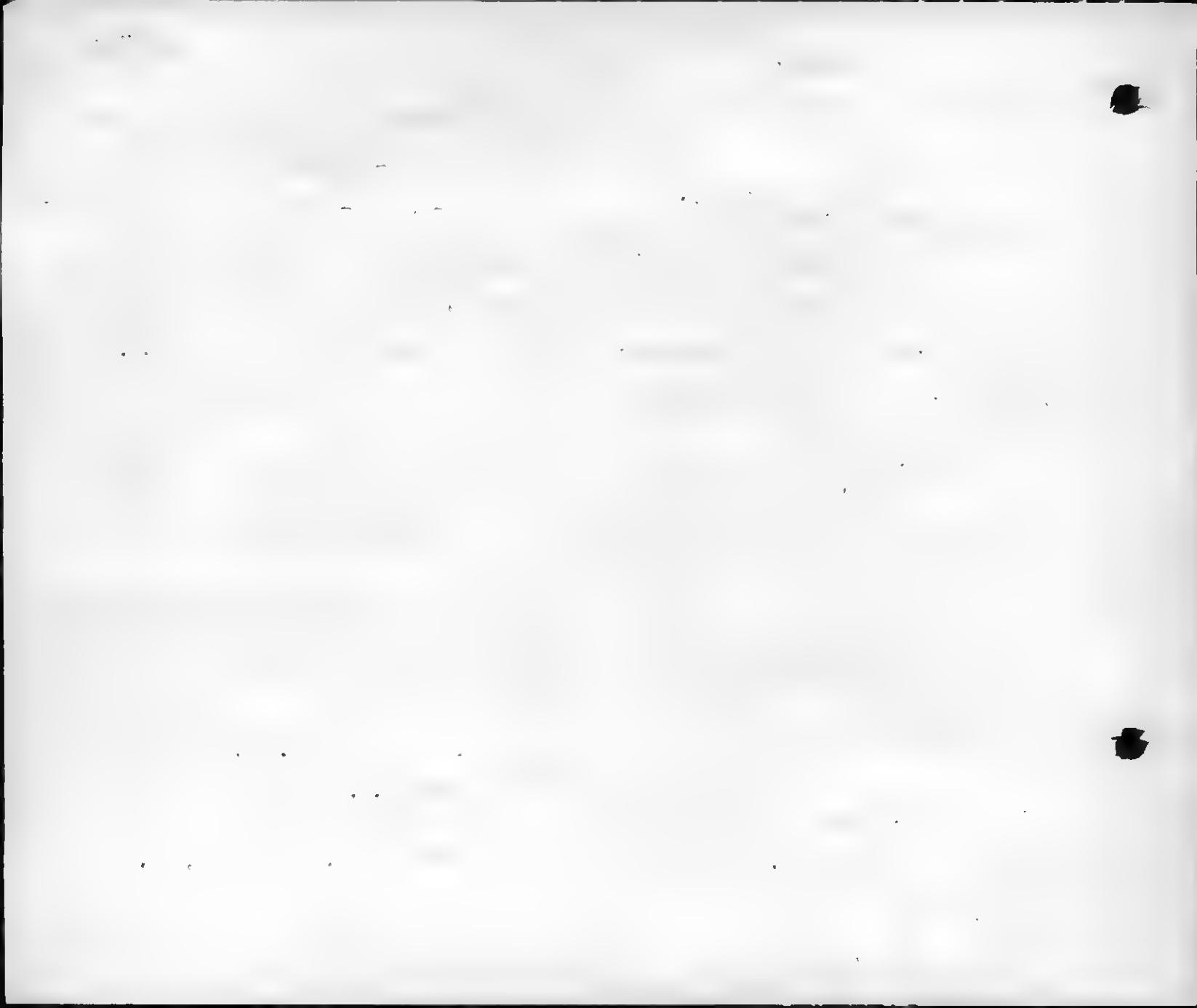
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8716

CERTIFICATE OF DEATH

08724

1. PLACE OF DEATH o COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival). Anne Arundel General Hospital				d. STREET ADDRESS Rt-3, Box-1692	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Thomas	Middle L.	Last KINNEY	4. DATE OF DEATH	Month August Day 21 Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 19, 1900	9. AGE (In years lost birthday) 60 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Thomas J. Kinney		14. MOTHER'S MAIDEN NAME Lennie Phillips		Address # 2	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Edda Dale Kinney	
(Yes, no, or unknown) (If yes, give war or dates of service)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		ARTERIOSCLEROTIC HEART DISEASE		Unknown	
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20, 1960, to Aug. 21, 1960, that (I) (we) last saw the deceased alive on 18 AUG 1960, and that death occurred at M, from the causes and on the date stated above		22a. SIGNATURE Edward S. Beck			
		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 71 Franklin St., Annapolis, Md.			
Edward S. Beck		23a. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 8/24/1960 23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest 23d. LOCATION (City, town, or county) Annapolis Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John M Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR ADDRESS 25b. REGISTRAR'S SIGNATURE DATE AUG 25 '60 C. L. Kinney			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

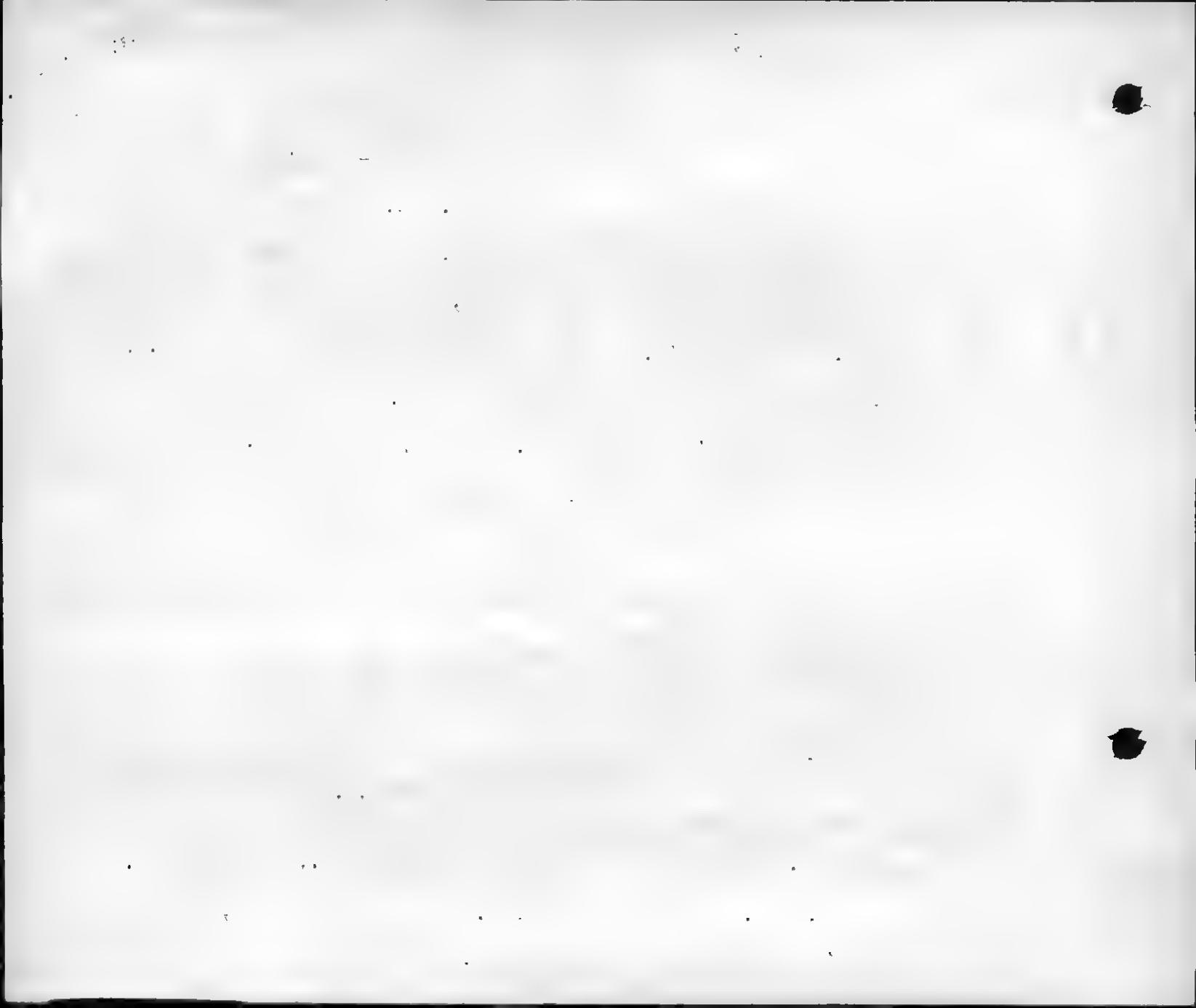
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08725

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) Isabel		First	Middle
4. DATE DEATH KIRBY		Month August	Day 31
5. SEX Female		6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 26, 1909		9 AGE IN years 51 yrs. last birthday	
10a US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Dep't. Store	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry S. Warthen		14 MOTHER'S MAIDEN NAME Anne M. Sheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT 1111111111111111 Mr. James E. Kirby Same as #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Osteoneuritic nephrosis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. X (b) <i>Diabetes mellitus</i>		10 yrs.	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) attended the deceased from July 1958, to August 1960, that (I) last saw the deceased alive on August 30, 1960, and that death occurred at M, from the causes and on the date stated above.		3:20 P.M.	
22a. SIGNATURE <i>John L. Hedeman</i>		22b. DATE SIGNED 9/1/60	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3rd Sept. 1960	
23c NAME OF CEMETERY OR CREMATORIAL Glen Haven Cemetery		23d LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Brightman</i>		ADDRESS Glen Burnie, Md.	
25a REC'D BY REGISTRAR SEP 6 '60		25b REGISTRAR'S SIGNATURE <i>Clifford S. Krause</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.

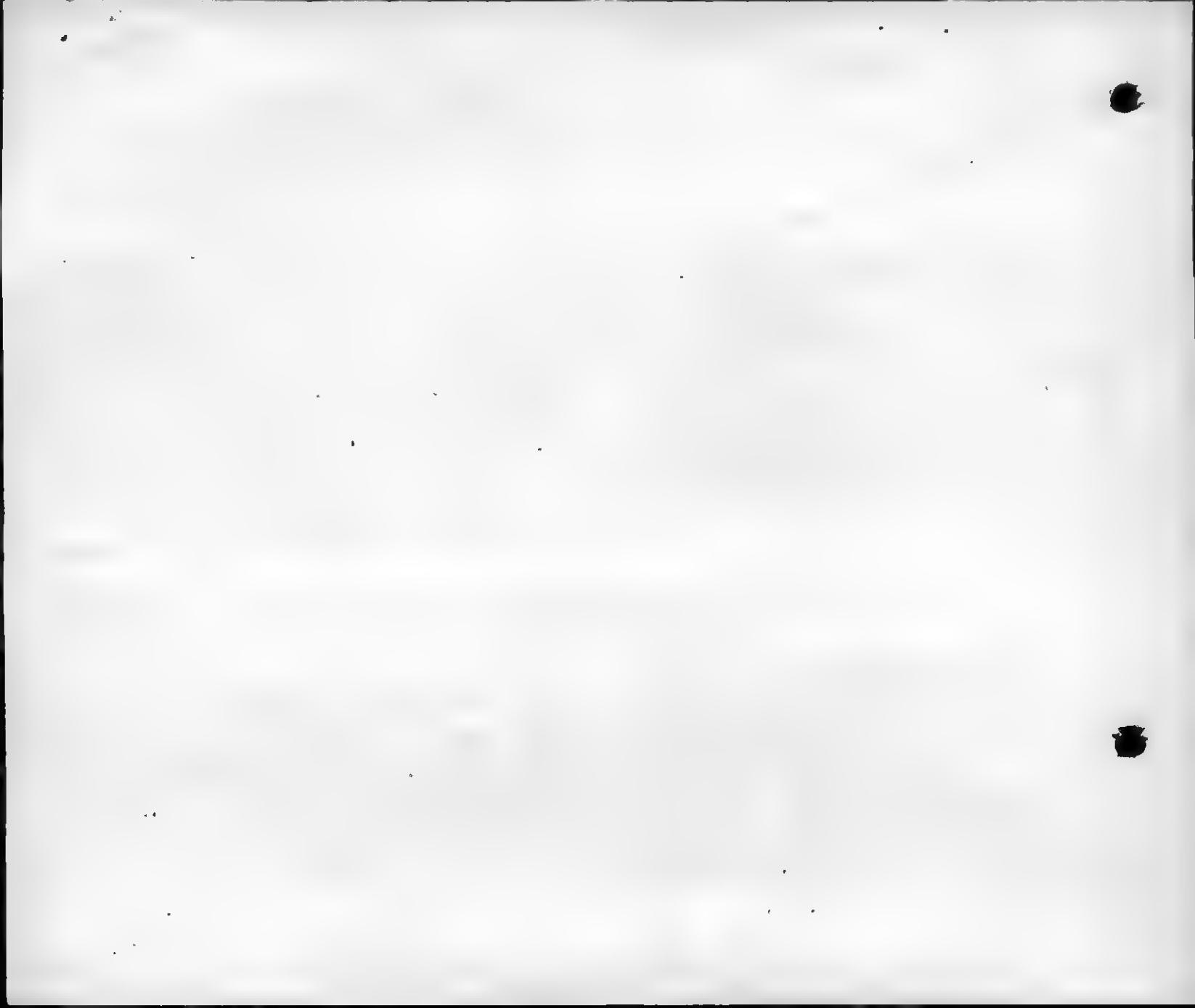
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08726

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Same		b. COUNTY Severe			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Pitchle Highway						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emilie Elsa Breckel Krutzfeldt		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/24/06	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Breckel				14. MOTHER'S MAIDEN NAME Catherine Mueller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Ernest Krutzfeldt (husband)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of left ovary									
DUE TO 15.0									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
DUE TO (b) (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/7/60 , 19, to 9/16/60 , 19, that (I) (we) last saw the deceased alive on 8/15/60 , 19, and that death occurred at 1.30 PM from the causes and on the date stated above									
22a. SIGNATURE Gustave H. Faubert		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE SIGNED 8/16/60	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.									
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 19, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial		23d. LOCATION (City, town, or county) Glen Burnie, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.									
25a. REC'D BY REGISTRAR DATE AUG 19 '60								25b. REGISTRAR'S SIGNATURE Charles L. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08727

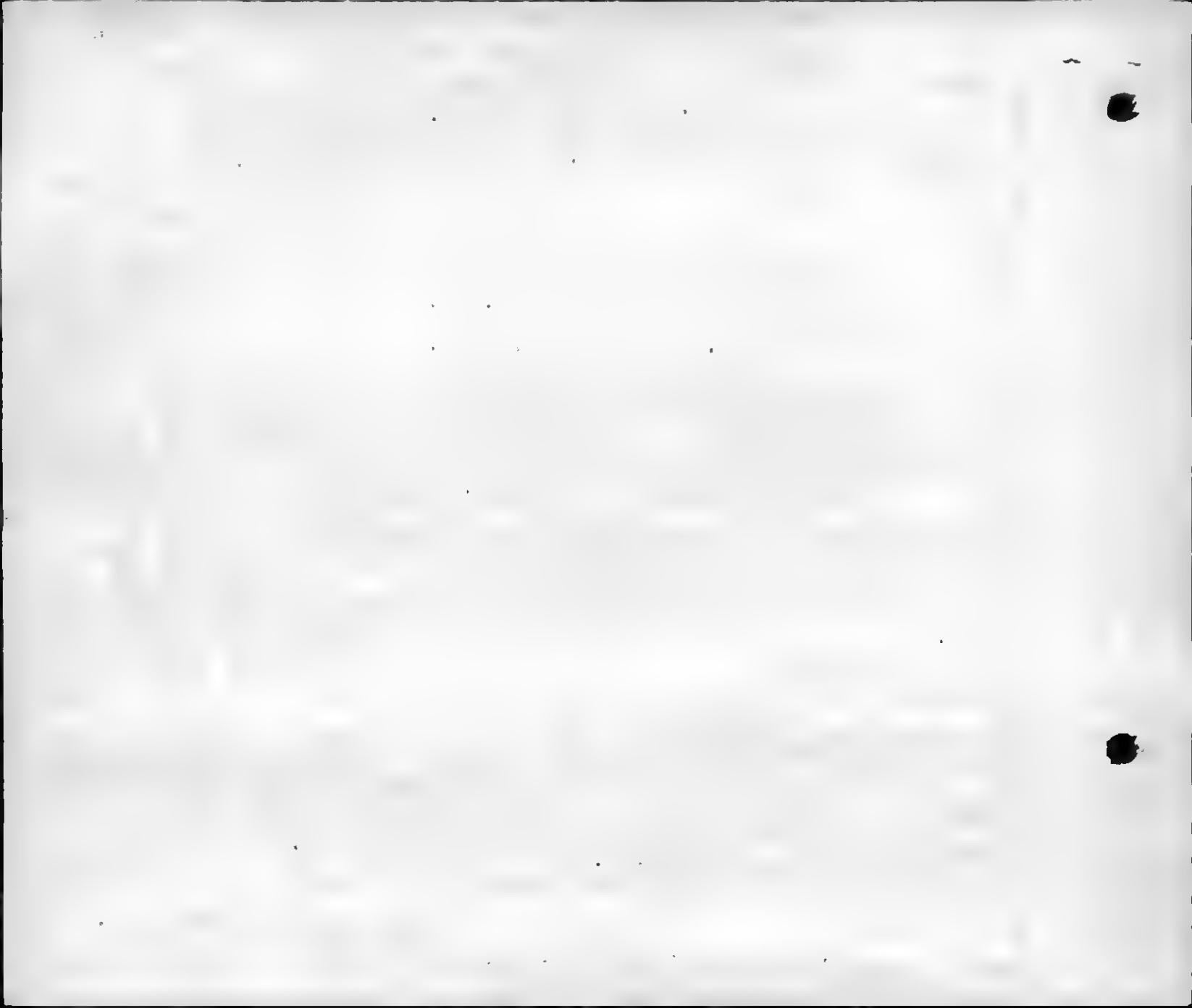
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven	c. LENGTH OF STAY IN 1b 25 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven Manor, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Fairhaven Manor	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Francis Joseph	Middle Little	Last
4. DATE OF DEATH	Month August	Day 13,	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1896
9. AGE (In years from birth) 64	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive	10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tele. Co.	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Harry Little	14. MOTHER'S MAIDEN NAME Katherine Sullivan	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Elizabeth Owings Little	Fairhaven Manor
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 57X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		INTERVAL BETWEEN ONSET AND DEATH 8 Months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 2nd 1959</u> to <u>8/13/60</u> , 19_____, that I last saw the deceased alive on <u>8/12/60</u> , 19_____, and that death occurred at <u>11:00</u> PM, from the causes and on the date stated above. ACTUAL SIGNATURE <u>John Russell Davis</u> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) John Russell Davis, M.D. DATE SIGNED Medical Arts Bldgs, 8/13/60 Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60	22c. NAME OF CEMETERY OR CREMATORIUM Our Lady of Sorrows Cemetery
22d. LOCATION (City, town, or county) Owensville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Marlboro, Md.		24a. REC'D BY REGISTRAR AUG 23 '60	24b. REGISTRAR'S SIGNATURE John S. Knue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8767

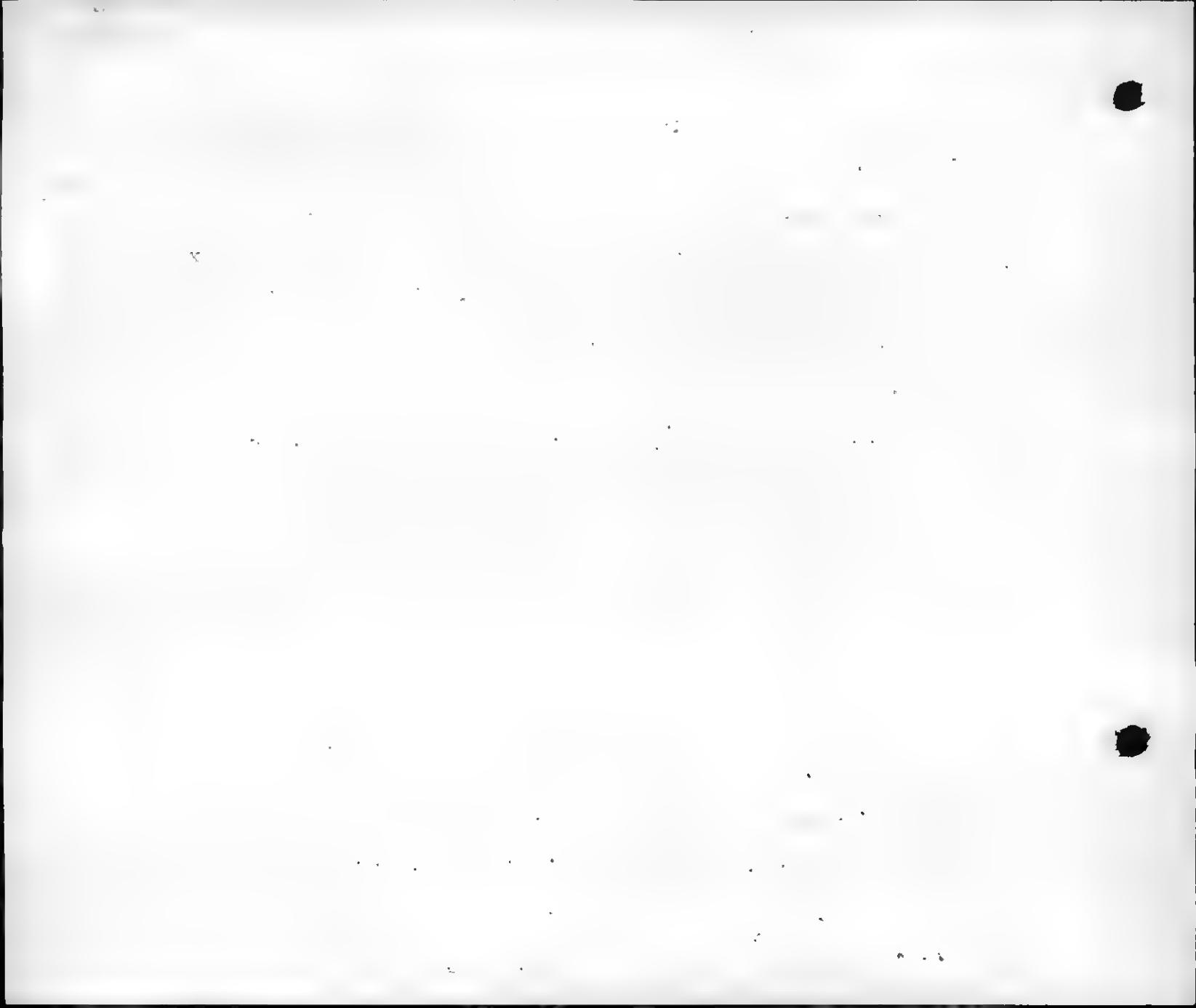
CERTIFICATE OF DEATH

08728

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed by or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>31 Bloomsbury Sq.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Knollingwood Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CARRIE LOWMAN</i>		First	Middle	Last	4. DATE OF DEATH AUGUST 10 1960	Month	Day	Year	
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH June 8, 1883	9. AGE (In years loss of birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) <i>Orienton, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Joshua Meek</i>				14. MOTHER'S MAIDEN NAME <i>Martha (unknonw)</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <i>Husband's 214 OF 0201</i>		INFORMANT Frank Thomas Lowman S ^t . husband- same as # 2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>332x</i>		DUE TO <i>Cerebral Artery Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i>(c)</i>							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Annapolis</i>		(County) <i>Anne Arundel</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>August 1958</i> , to <i>8/10 1960</i> that I last saw the deceased alive on <i>8/9 1960</i> and that death occurred at <i>4:20 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Annapolis, Maryland</i>							DATE SIGNED <i>Richard N. Reeler</i>
ACTUAL SIGNATURE <i>Richard N. Reeler</i>		PHYSICIAN'S NAME (Type) <i>Richard N. Reeler MD</i>							121 Cathedral St., Annapolis, Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 13, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Maryland</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Keeler</i>		ADDRESS <i>Huntington Funeral Home Annapolis, Maryland</i>		24a. REC'D BY REGISTRAR <i>AUG 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keeler</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8768

CERTIFICATE OF DEATH

08729

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper; Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. STREET ADDRESS 722 Charles Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alice		First	Middle	Last	4. DATE OF DEATH McDonald	Month 8	Day 28	Year 1960		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 20, 1932	9. AGE (In years last birthday) 28 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Diana Daugherty						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Paranoid Type									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Wife not white at work							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. 19	Month, Day, Year p. m. -----	20d. INJURY OCCURRED Wife not white at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----				
21. I certify that I attended the deceased from 3/6 , 19 59 , to 8/28 , 19 60 , that I last saw the deceased alive on 8/28 , 19 60 , and that death occurred at 4:45A.M. from the causes and on the date stated above.									ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	DATE SIGNED 8/29/60
ACTUAL SIGNATURE 	M.D. Crownsville State Hospital, Md. 8/29/60									
PHYSICIAN'S NAME (Type) L. Benedict, M. D.	Crownsville State Hospital, Md. 8/29/60									
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL 9-1-60	22b. DATE THEREOF 9-1-60	22c. NAME OF CEMETERY OR CREMATORIUM MOUNT AUBURN	22d. LOCATION (City, town, or county) BALTIMORE, Md.	(State) -----						
23. FUNERAL DIRECTOR'S SIGNATURE ISIAH L. BROWNSON	ADDRESS 108 W. MONTGOMERY	ST. -----	24a. REC'D BY REGISTRAR -----	24b. REGISTRAR'S SIGNATURE Clifford S. Thomas	DATE JUN 31 '60					

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TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

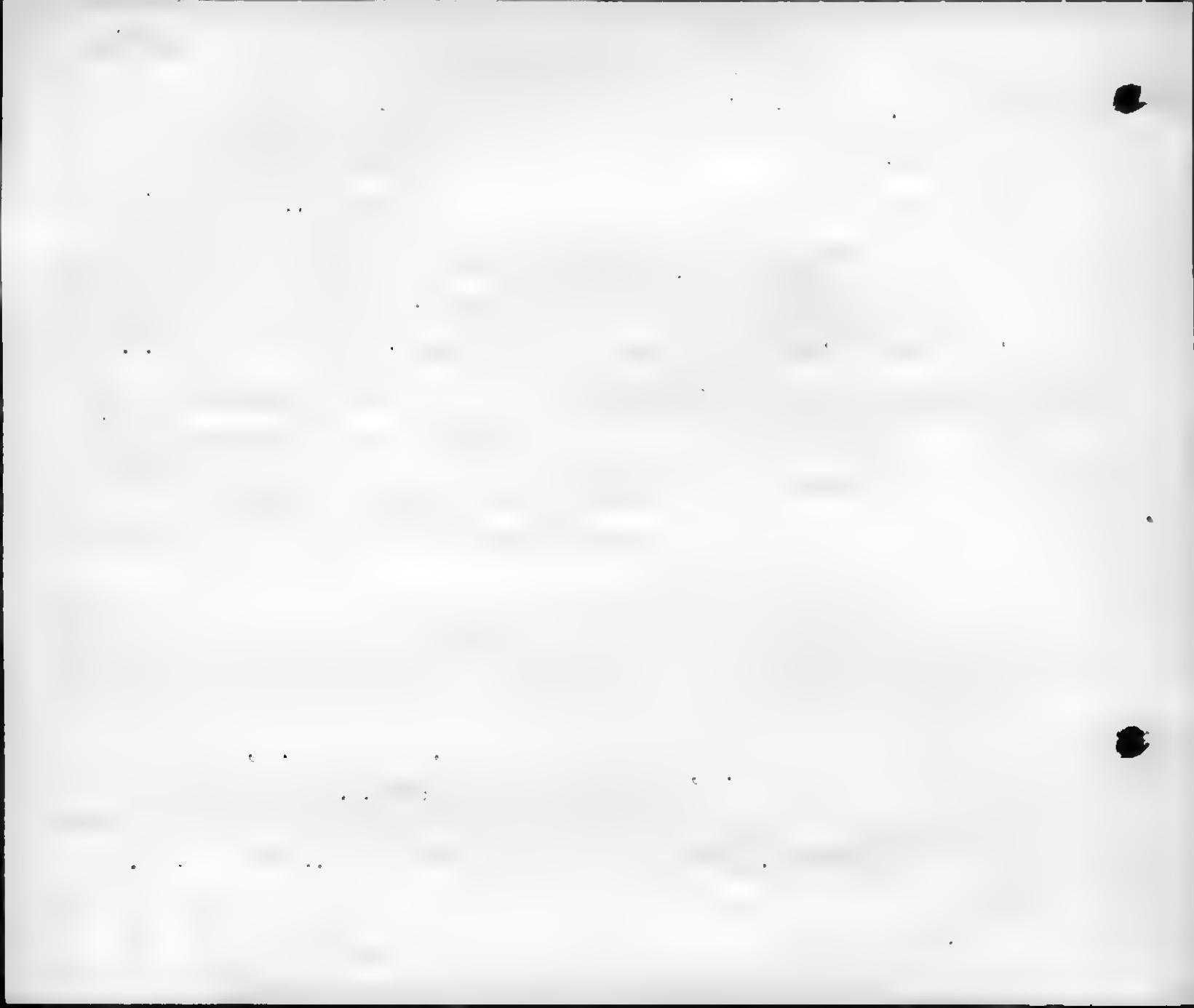
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8718

08730

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN b RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS 6 Murray Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle G.	Last MEREDITH
4. DATE OF DEATH	Month August	Day 3	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1887
9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 73	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pet-Lumber Dealer		14. KIND OF BUSINESS OR INDUSTRY Lumber	
15. BIRTHPLACE (State or foreign country) Virginia		16. CITIZEN OF WHAT COUNTRY? U.S.	
17. FATHER'S NAME William L. Meredith		18. MOTHER'S MAIDEN NAME Virginia Anderson	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		20. SOCIAL SECURITY NO 153-7-12345	
21. INFORMANT Mrs Iris Knight Meredith		22. ADDRESS 21 Cathedral St., Annapolis, Md.	
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. metastases		24. INTERVAL BETWEEN ONSET AND DEATH 3 mo -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
27. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		28. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
31. I certify that (I) (this hospital) attended the deceased from July 21, 1960 to Aug. 3, 1960 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Aug. 3, 1960 , and that death occurred at M. from the causes and on the date stated above.		32. ATTENDING PHYS. Richard N. Peeler MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
33. SIGNATURE Richard N. Peeler		34. DATE SIGNED 8/3/60	
35. PHYSICIAN'S NAME (Type) Richard N. Peeler		36. ADDRESS 121 Cathedral St., Annapolis, Md.	
37. BURIAL, CREMATION, REMOVAL (Specify) Burial		38. DATE THEREOF Aug 7-1960	
39. NAME OF CEMETERY OR CREMATORIAL Salem Church Cemt		40. LOCATION (City, town, or county) Gloucester Va	
41. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		42. ADDRESS Annapolis Md.	
43. REC'D BY REGISTRAR Clerk S. Kline		44. REGISTRAR'S SIGNATURE Clerk S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08731

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle WESLEY	Last Mitchell
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 31, 1903
9. AGE (In years last birthday) 56 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACK MAINTENANCE	10b. KIND OF BUSINESS OR INDUSTRY BTL R.R.C.	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME JOHN MITCHELL		
14. MOTHER'S MAIDEN NAME IDA PALMER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT MRS EDNA E. MULLIKIN
			Address 4100 48th St. 12 Cottage PK, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) Pulmonary embolism? Rheumatic Heart Disease 30 yrs mitral Stenosis & Dampfing			
INTERVAL BETWEEN ONSET AND DEATH 12 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Annapolis		(County) Anne Arundel	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 7 - C - 60 to 8 - 30 - 1960 , that (I) (we) last saw the deceased alive on 8-29-1960 , and that death occurred at 6 AM , from the causes and on the date stated above			
22a. SIGNATURE Frank M Shipley		22b. DATE SIGNED 8-30-60	
22c. PHYSICIAN'S NAME (Type) Frank M Shipley		22d. ADDRESS Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-2-1960	
23c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery		23d. LOCATION (City, town, or county) Baltimore City, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Frank M. Shipley, Jr.		25a. REC'D BY REGISTRAR DATE SEP 2 '60	
ADDRESS 1114 Champlin St. Annapolis, Md		25b. REGISTRAR'S SIGNATURE John S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08732

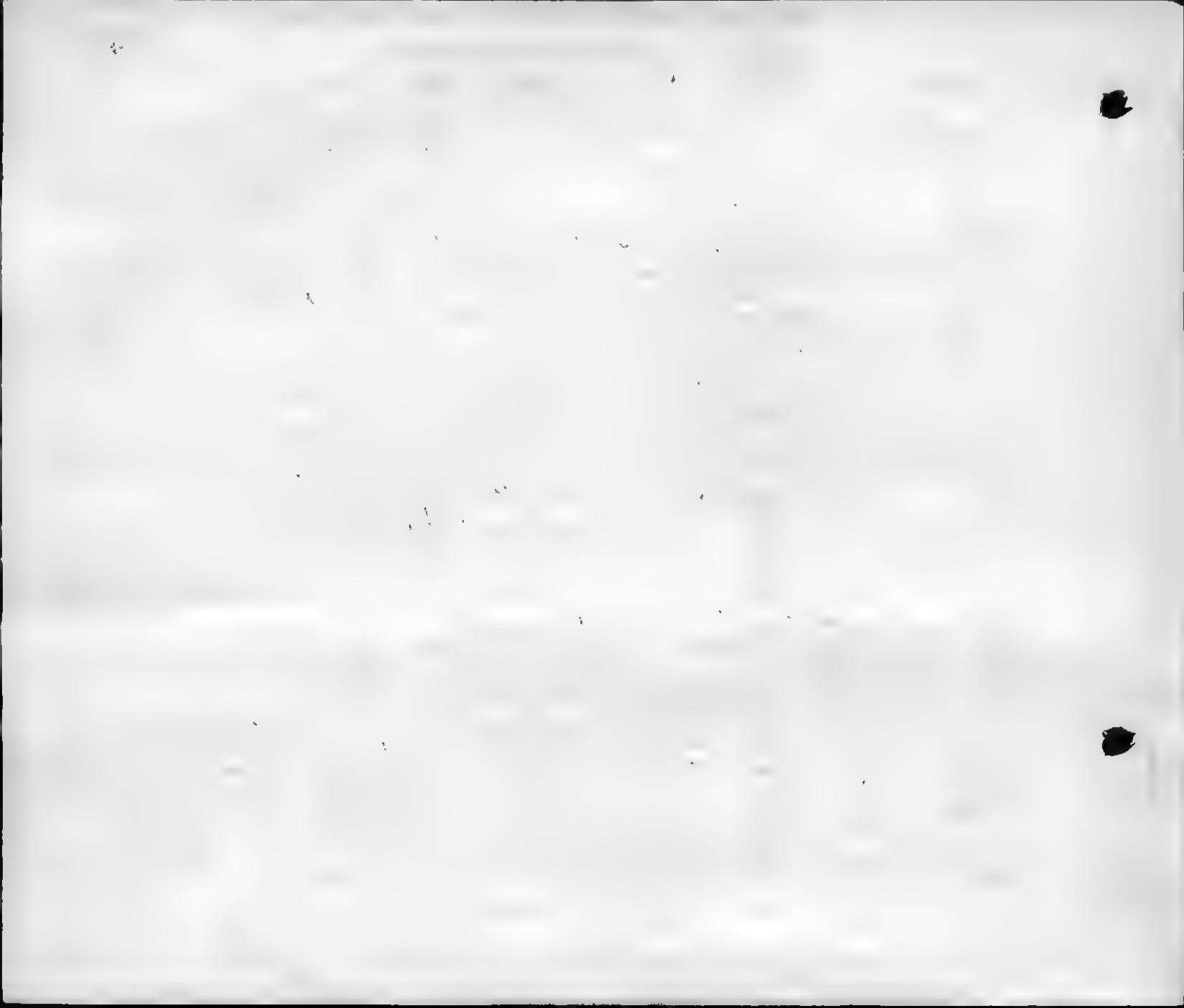
Reg. Dist. No.

8769

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		C. LENGTH OF STAY IN 1b Crownsville 1 mo, 12 d		d. STATE Md.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Crownsville State Hospital 3048 Accension Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MOZELLA	Middle MONTGOMERY	Lost	4. DATE OF DEATH 8
5. SEX F		6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/12	Month 8 Day 5 Year 1960
9. AGE (In years to the nearest year) 100 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Kitchen Helper		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Willie Carolina		14. MOTHER'S MAIDEN NAME Lulla Caroline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Hyperglycemia + Uremia Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Glioma				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral Glioma			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State)	
21. I certify that I attended the deceased from _____ to _____, 19_____, that I last saw the deceased alive on _____ and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) Crownsville State Hospital		DATE SIGNED Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cem	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Henley		ADDRESS 100 Brantley Ave.		24a. LOCATION (City, town or county) Anne Arundel Co	
				24b. REC'D BY REGISTRAR Date 8-10-60	
				24b. REGISTRAR'S SIGNATURE Ollie L. Hayes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

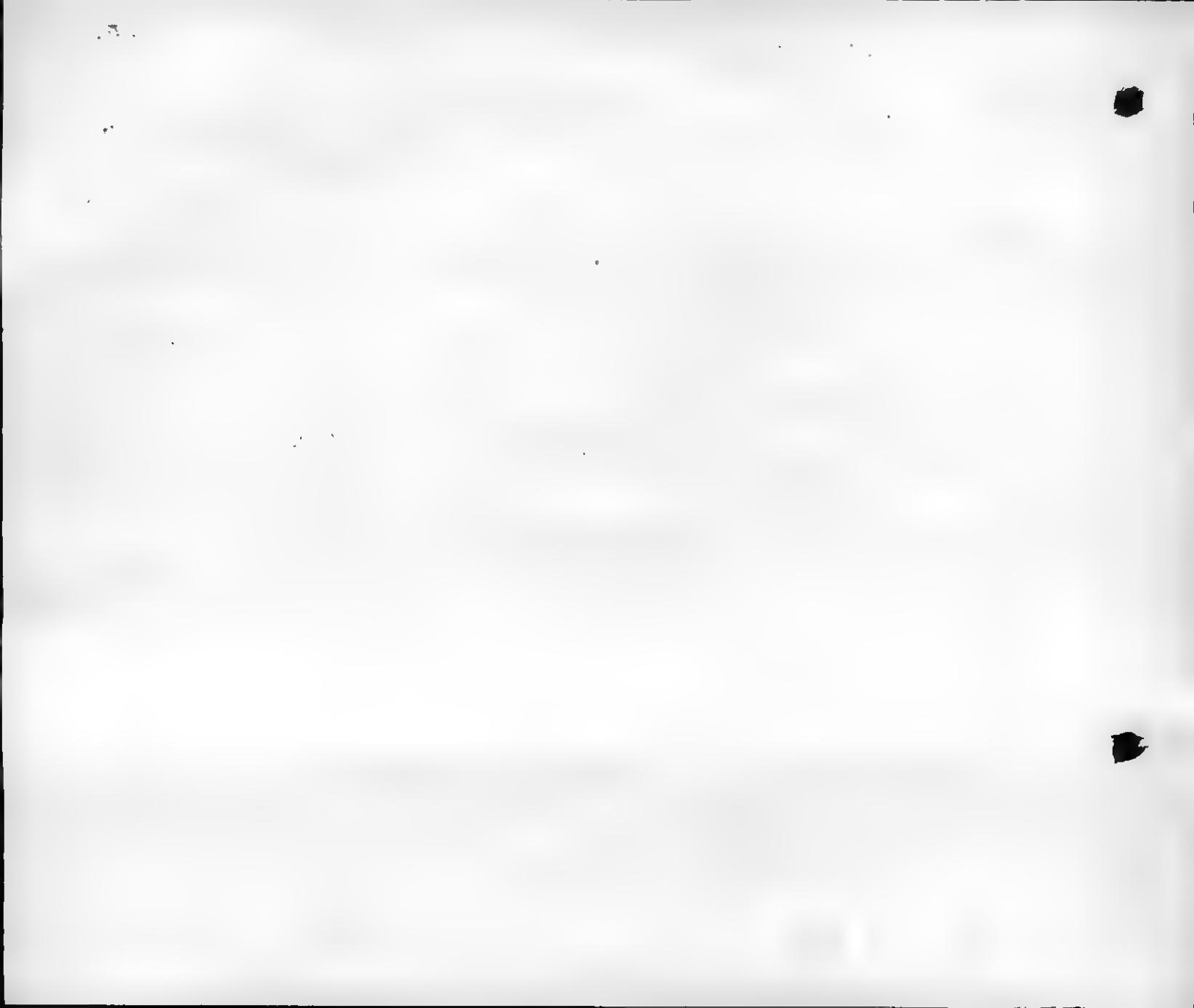
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8720

CERTIFICATE OF DEATH

08733

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) Charles		First W.	Middle Moravec SR
4. DATE OF DEATH August 16 1960		Month Month	Day Day
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1884
9. AGE (In years at birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairymen		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dairy	
10c. BIRTHPLACE (State or foreign country) Balto Md.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-32-6929	
17. INFORMANT Records at U.S. Navy Base Gambrills Md		Address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Due to (c) Due to		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastro-intestinal fistula -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____ Jan 1955 to Aug 16 1960 that (I) (we) last saw the deceased alive on Aug 16 1960 and that death occurred at 6 PM, from the causes and on the date stated above		22a. DATE SIGNED	
22b. SIGNATURE S. B. Brumback		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) S. B. Brumback		22d. ADDRESS Anne Street Bl & Annapolis Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial Aug 18-1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baldwin Memorial	23d. LOCATION (City, town, or county) Millersville
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md		25a. REC'D BY REG STAR DATE AUG 18 '60	25b. REGISTRAR'S SIGNATURE C. K. S. Times



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8770

CERTIFICATE OF DEATH

08734

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6 yrs. 3 mo. 15 days		b. COUNTY Vienna	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown R.F.D.	
e. NAME OF DECEASED (Type or print) Talbot		First	Middle	Lost Morris	4. DATE OF DEATH Month 8 Day 11 Year 1960
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1910 March 17, 1910	9. AGE (In years lost b'f' birthday) 50 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Farming and Factory Work		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland (Dorchester Co.) U.S.A.	
13. FATHER'S NAME James Morris		14. MOTHER'S MAIDEN NAME Jane ?		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary K. dren. a S22X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/26 , 1954, to 8/11 , 1960, that I last saw the deceased alive on 8/11 , 1960, and that death occurred at 9:00 A.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 8/12/60					
ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. 8/12/60					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 8/12/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-60		22c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery	
22d. LOCATION (City, town, or county) Vienna, Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE J. Brampton Son Federalsburg md.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
24b. REGISTRAR'S SIGNATURE John S. Evans					



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 10a, telephone 311, W.J. Schner & Sons 8/2/108735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i> <i>Hgts.</i>		c. LENGTH OF STAY IN 1b <i>41 mo.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Louis General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>James E. Morton</i>	First <i>J</i>	Middle <i>E</i>	Last <i>Morton</i>	
4. DATE OF DEATH <i>Aug 27 1960</i>	Month <i>Aug</i>	Day <i>27</i>	Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3 1915</i>	
9. AGE (In years lost birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Dept. of Mil. Supply Vehicles</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Washington D.C.</i>	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James E. Morton</i>	14. MOTHER'S MAIDEN NAME <i>Emerson Bell Morton</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>James Morton</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac vascular Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <i>(b)</i> DUE TO <i>(c) Arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> to <i>8/27/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>8/27/60</i> , 19 <i>60</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Linthicum, Md.</i> DATE SIGNED <i>8/27/60</i>				
ACTUAL SIGNATURE <i>James J. Linnick & Sons - Balto.</i>	PHYSICIAN'S NAME (Type) <i>James J. Linnick & Sons - Balto.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>	22b. DATE THEREOF <i>8/30/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Mount Crem.</i>	22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Linnick & Sons - Balto.</i>	ADDRESS <i>17 N. Main St.</i>	24a. REC'D BY REGISTRAR DATE AUG 25	24b. REGISTRAR'S SIGNATURE <i>Wm. J. Linnick & Sons - Balto.</i>	

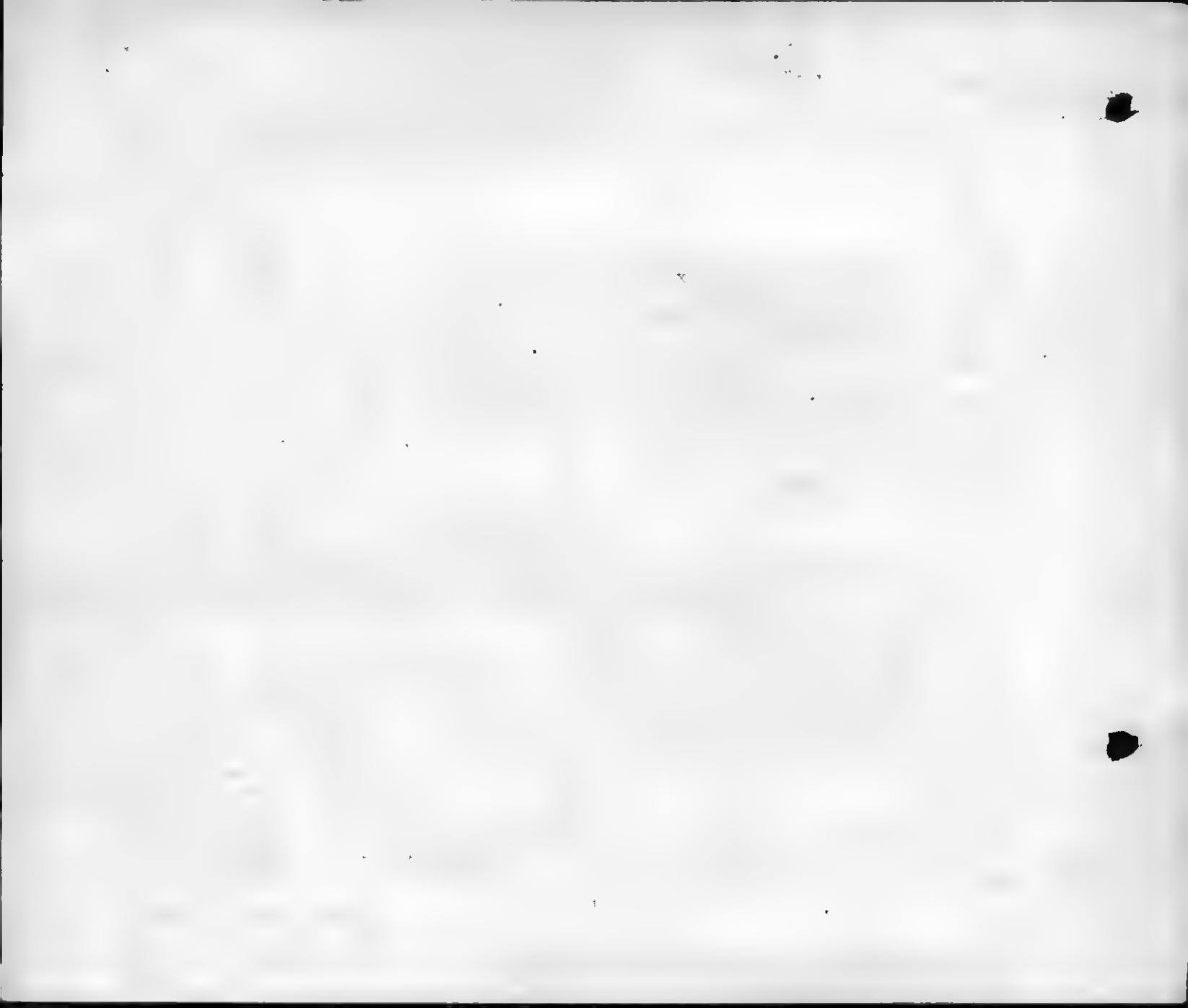


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: As this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

File 26 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
-26-60 ams 8721 CERTIFICATE OF DEATH 08736
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Anne Arundel ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNEAPOLIS		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNEAPOLIS		d. STREET ADDRESS 8 CLINTON AVE.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Andrew	Middle J	Middle MUSTERMAN	4. DATE OF DEATH AUGUST 13 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 24, 1900	9. AGE (In years lost birthday) 52 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gan and Elect Co.		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Andrew H. Musterman		14. MOTHER'S MAIDEN NAME Catherine Smith				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. WVI 212 05 6388		17. INFORMANT Mrs. Estelle F. Musterman - wife - sole prop.		18. CAUSE OF DEATH [Enter only one cause per line for Part I (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 971.8 DUE TO Poisoning - Liver Failure INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		(b) DUE TO digestion of insecticide (self-inflicted)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) SUICIDE						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ANNAPOLIS		(County) AA	(State) MD	
21. I certify that I attended the deceased from 8-10-60, 1960, to 8-13-, 1960, that I last saw the deceased alive on 8-13-1960, and that death occurred at 4:45 P.M., from the causes and on the date stated above ACTUAL SIGNATURE James R. Martin M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 8-15-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR AUG 18 '60		24b. REGISTRAR'S SIGNATURE Orville S. Kress		
				DATE				



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

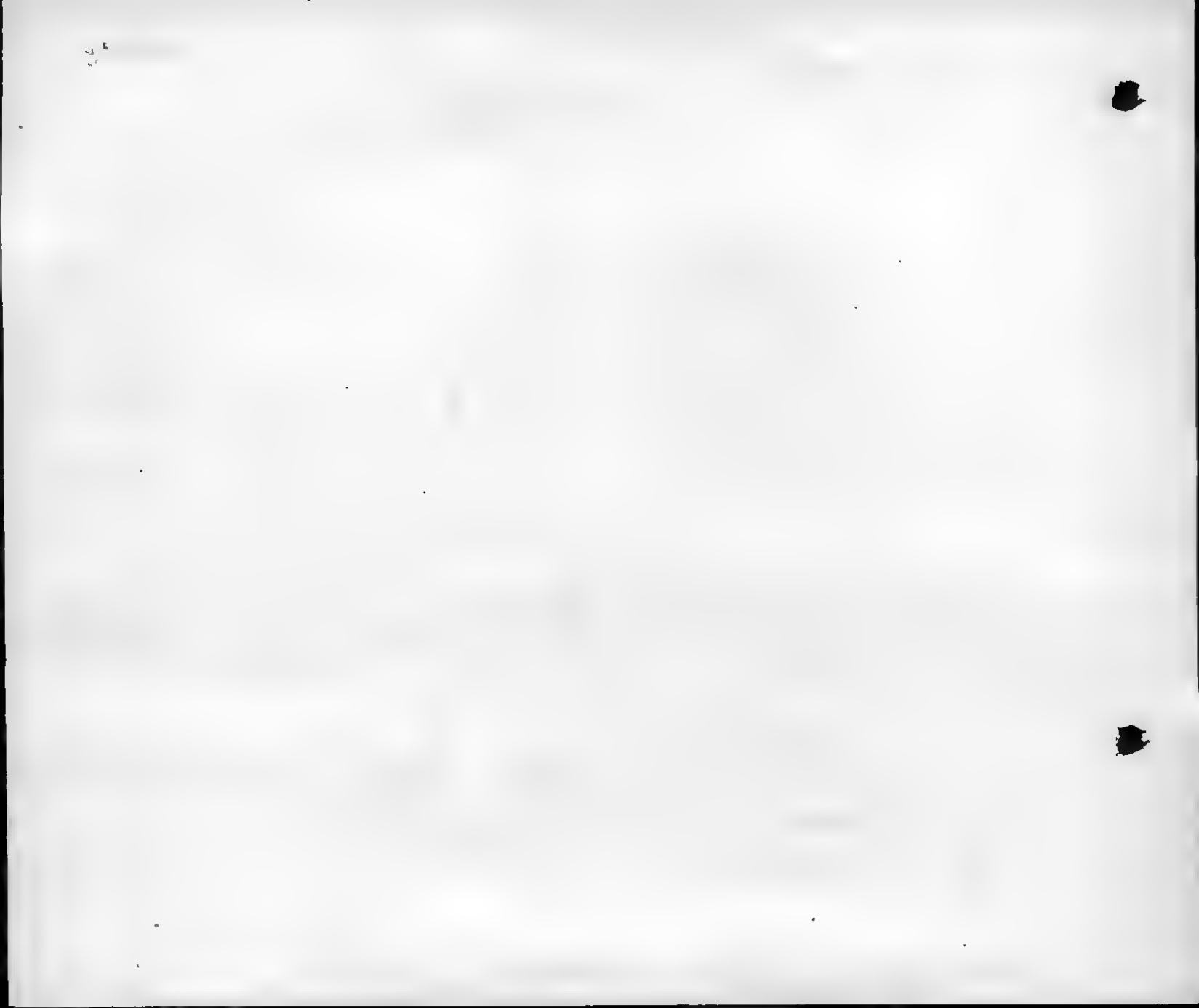
FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08737

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>AA County</i>	
d. LENGTH OF STAY IN 1b <i>22 yrs.</i>		d. STREET ADDRESS <i>A Pasadena, Md.</i>	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>GAYFIELD'S FARM Mt.Rd. Pasadena</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Joseph O'Meara</i>		First <i>William</i>	Middle <i>Joseph</i>
4. DATE OF DEATH <i>Aug. 29</i>		Month <i>Aug.</i>	Day <i>29</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cau</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 9, 1889</i>		9. AGE (In years last birthday) <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor.</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>ANNA ROTHANA</i>		13. FATHER'S NAME <i>James J. O'Meara</i>	
14. MOTHER'S MAIDEN NAME <i>ANNE FERGUSON</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Son.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Coronary Occlusion Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH <i>Survived.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Aug. 29 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE 1960</i> to <i>Aug. 29</i> , that (I) (we) last saw the deceased alive on <i>Aug. 1960</i> and that death occurred at <i>9:30 AM</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>Richard C. Reba</i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard C. Reba</i>		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 30, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cathedral</i>		23d. LOCATION (City, town, or county) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard C. Reba</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director's office, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

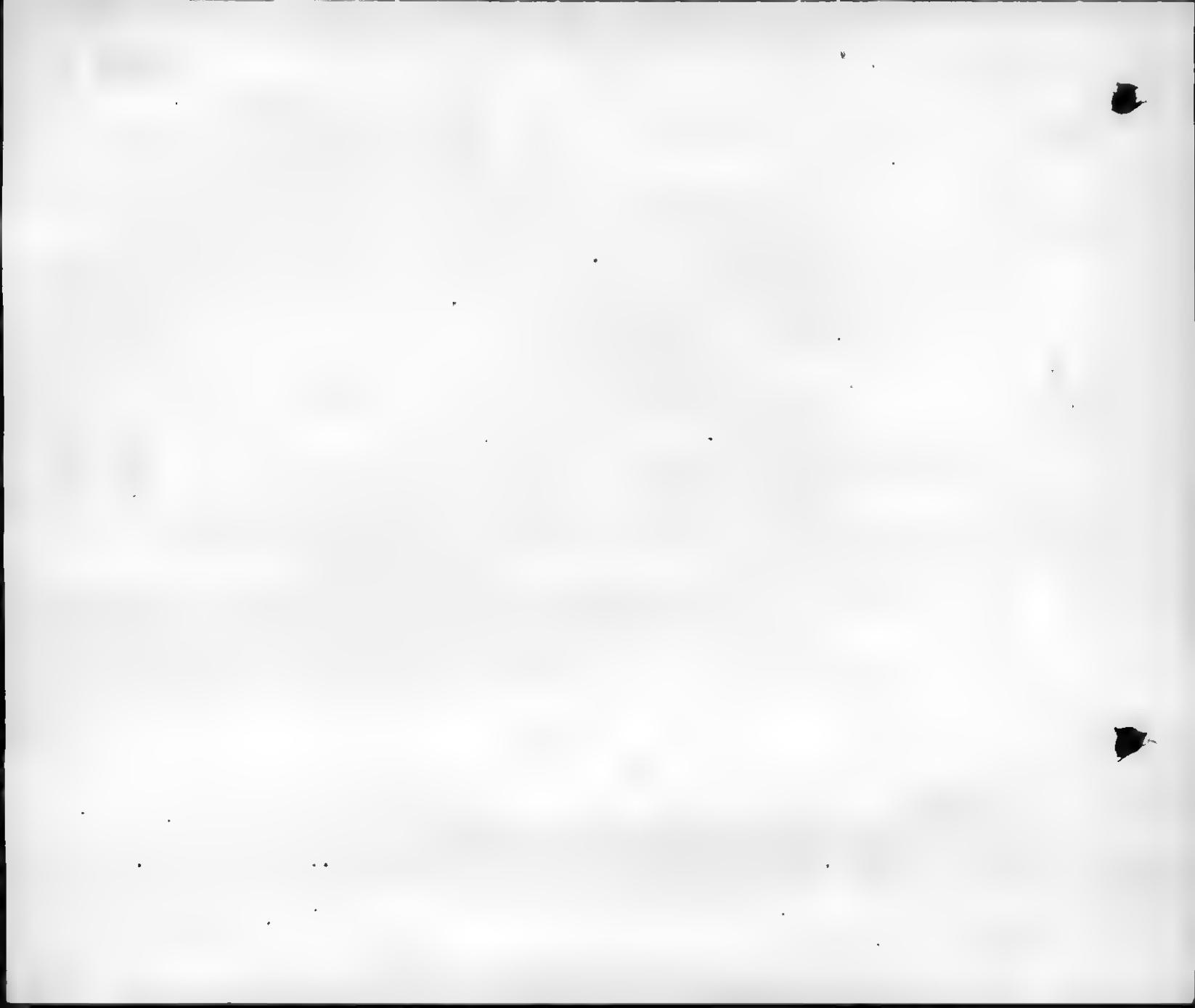
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
Item 8 FilmG2b9 8-19-60 et													
8773 CERTIFICATE OF DEATH 08738 Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drury		d. STREET ADDRESS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Edward</i>				First	Middle	Last	4. DATE OF DEATH <i>Owens</i> August 14 1960						
5. SEX <i>Male</i>		6 COLOR OR RACE <i>Colored</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7/28/1876</i> 1876				9. AGE (in years last birthday) <i>83</i> yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					
13. FATHER'S NAME <i>Wilson Owens</i>				14. MOTHER'S MAIDEN NAME <i>Matilda Langford</i>				12. CITIZEN OF WHAT COUNTRY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Mrs. Matilda Riggs- Drury, Maryland</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				<i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>immed</i>					
<i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b)	<i>Hypertensive Cardio Vascular Disease</i>				DUE TO (c)	<i>Respiratory</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>Mar 1960</i> to <i>Aug 14, 1960</i> , that I last saw the deceased alive on <i>Aug 14, 1960</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above													
ACTUAL SIGNATURE <i>R.B. Passer M.D.</i> ADDRESS (Street, city or town, state) <i>Upper Marlboro</i> DATE SIGNED <i>14 Aug 60</i>													
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/18/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Moses Cemetery</i>				22d. LOCATION (City, town, or county) <i>Anne Arundel Co., Maryland</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clara R. Grotzsch</i>				ADDRESS <i>30 H Street, N.E.</i>				24a. REC'D BY REGISTRAR <i>AUG 16 1960</i>					
								24b. REGISTRAR'S SIGNATURE <i>Charles S. Moore</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A duplicate certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		08739					
8722																	
1. PLACE OF DEATH a. COUNTY		Anne Arundel			MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission)		o STATE Maryland			Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis			c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Anne Arundel General Hospital					e. STREET ADDRESS		307 North Glen Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Grace			Middle D.		Last Owings		4. DATE OF DEATH		Month August		Day 30		Year 1960		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours		13. CITIZEN OF WHAT COUNTRY? USA	
Female		White				June 1, 1878		82 yrs									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
House wife		own home		Maryland		USA											
13. FATHER'S NAME		William Dawson		14. MOTHER'S MAIDEN NAME		Margaret Simmons											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT		Address											
		none		Hospital records													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Central Thrombosis										INTERVAL BETWEEN ONSET AND DEATH 6 weeks.					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		(b)		Candidans, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(c)		DUE TO		Artificial ventricular C. V. Shunt					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Hour a. m. p. m.		Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from July 20, 1960, to August 30, 1960, that (I) (we) last saw the deceased alive on Aug. 30, 1960, and that death occurred at 1:15 P.M. from the causes and on the date stated above.		22c. SIGNATURE Maurice Klawans,		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Aug. 30, 1960					
22c. PHYSICIAN'S NAME (Type)		Dr. Maurice Klawans		22d. ADDRESS		Southgate Ave., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Urinal		23b. DATE THEREOF Sept 2, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Forest Hill Cemetery		23d. LOCATION (City, town, or county) Galesville, Maryland		(State)									
24. FUNERAL DIRECTOR'S SIGNATURE Hoping Funeral Home		ADDRESS Annapolis, Maryland		25a. REC'D BY REGISTRAR DATE SEP 1 '60		25b. REG STRAR'S SIGNATURE Arthur S. Krause											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

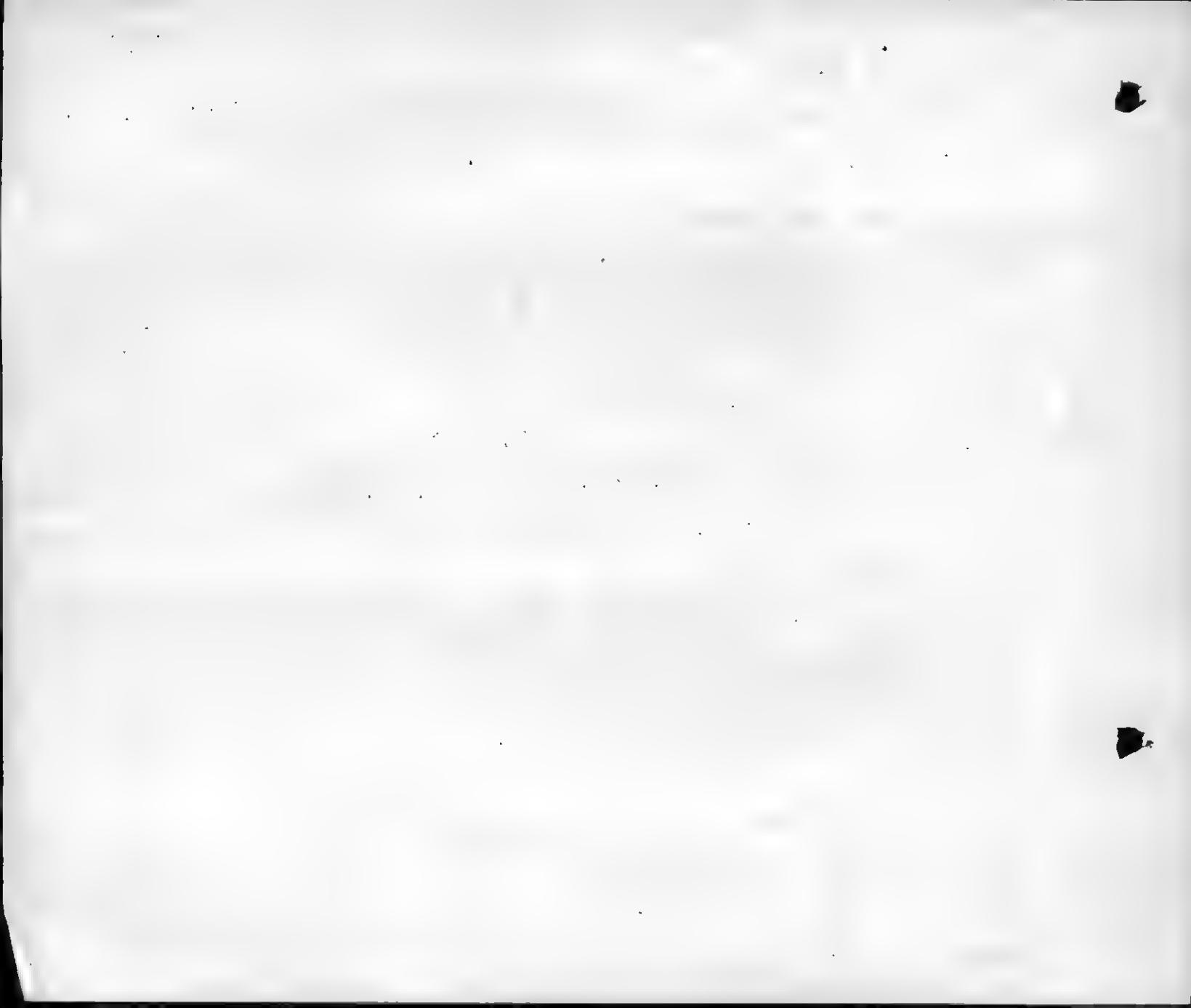
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8774

08740

1. PLACE OF DEATH a. COUNTY <i>HAN ARUNDEL</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FERRY FARMS</i>		c. LENGTH OF STAY IN 16 <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>OLD Annapolis Blvd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CLO Annapolis Blvd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Sabre</i>	Middle <i>C.</i>	Last <i>Pate</i>	4. DATE OF DEATH <i>8-3-1960</i>	Month <i>8</i>	Day <i>3</i>	Year <i>1960</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-17-1878</i>		9. AGE (In years last birthday) <i>82 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Hours <i></i>	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		10c. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>CLEMENT MOYLEY</i>		14. MOTHER'S MAIDEN NAME <i>? MEADOR</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>William A. Pate</i>		Address <i># 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>421</i>		DUE TO <i>Myocardial Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 month</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) <i>Arteriosclerotic Heart Disease</i>				 <i>6 month</i>			
DUE TO <i></i>		(c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of Colon</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-1-1960 to 8-3-1960</i> , that (I) (we) last saw the deceased alive on <i>8-2-1960</i> , and that death occurred at <i>4-15-1960</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>James R. Martin</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE SIGNED <i>8/3/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		22d. ADDRESS <i>ANNAPOLIS, MD.</i>							
23a. BURIAL, CREMATION REMOVAL (Specify) <i>8-27-1960</i>		23b. DATE THEREOF <i>8-27-1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fordsville Cemetery</i>		23d. LOCATION (City, town, or county) <i>FORDSVILLE Ky.</i>		(State) <i></i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons Crem. & Mort. Mfr.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Trahan</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08741

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

8723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

MARYLAND

Deep Creek - Maryland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.S. - Anne Arundel General

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4 DATE
DEATH

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

W

WIDOWED DIVORCED

1-17-09

9 AGE (in years
from birthday)
51 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Teacher

10b. KIND OF BUSINESS OR INDUSTRY

Balto. City Schools

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Powell

14. MOTHER'S MAIDEN NAME

Alice V. Cunningham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

George C. Powell, Jr., Severna Park, Md

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Causes disease

INTERVAL BETWEEN
ONSET AND DEATH
Severna

44 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREOpen book
E. L. WharffM.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

8-14-60.

22a. BURIAL, CREMATION
REMOVAL (Specify)

BURIAL 8-17-60

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Meadowridge Cemetery

22d. LOCATION (City, town, or county)

Elkridge, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Wm. Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR

DATE AUG 17 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

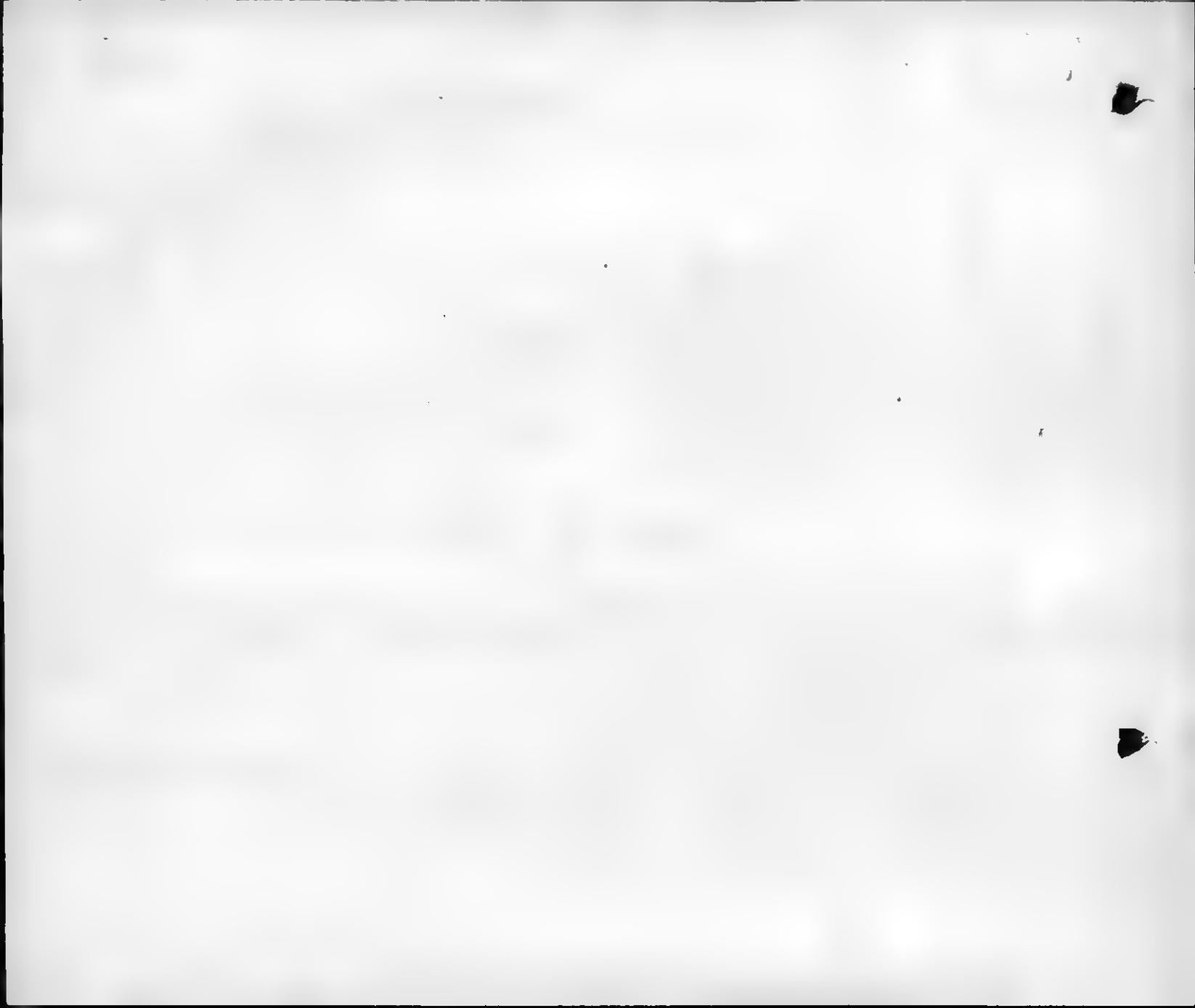
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8724

08742

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
<i>AA</i> MARYLAND		Md.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>207 Wardour Drive</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
3. NAME OF DECEASED (Type or print)		First <i>Alexander</i>	Middle <i>S.</i>
4. DATE OF DEATH		Month <i>Aug</i>	Day <i>26</i> Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post Postmaster</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	11. BIRTHPLACE (State or foreign country) <i>New York City</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Samuel Proskey</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Cobb</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mary M. Proskey</i> (2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> 10 yrs.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>APRIL 1957 to 23 AUG 1960</i> , that (I) (we) last saw the deceased alive on <i>23 AUG 1960</i> , and that death occurred <i>23 AUG 1960</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Beck MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 28 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St Margarets Cemt St Margarets Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Kelly LMS Annapolis Md</i>		25a. REC'D BY REGISTRAR DATE <i>Arthur S. Kraus Aug 30 '60</i>	25b. REGISTRAR'S SIGNATURE



FOR STATE
HEALTH DEPT.

M

VS. AT5ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21201

8750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
• COUNTY
Anne Arundel

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Severna Park

c. LENGTH OF STAY IN lb
2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Severn River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND
Maryland
STATE
A b. COUNTY
A. b.

e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Millersville

f. STREET ADDRESS
Crain Highway

g. IS RESIDENCE ON A FARM?
YES NO

3. NAME OF DECEASED
(Type or print)
Earl James Pumphrey

First Middle Last

4. DATE OF DEATH
August 5th. 1960

5. SEX
M W

6. COLOR OR RACE
7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH
6/20/96

9. AGE (In years last birthday) IF UNDER 1 YEAR
64 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY
Farmer for self

11. BIRTHPLACE (State or foreign country)
Millersville, Md.

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME
Walter Pumphrey

14. MOTHER'S MAIDEN NAME
Susanna Wade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO
(Yes, no, or unknown) (If yes, give war record and service)
Yes 1918 W.W.I 218-363686

17. INFORMANT
Mrs. Josephine Pumphrey (wife)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a).
420-1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last.
DUE TO
(c)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH
Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)

19. WAS AUTOPSY PERFORMED?
YES NO

20e. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED While at work Not While at work
p.m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner
Gustave H. Faubert, M.D.

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
M.D.
DEPUTY MEDICAL EXAMINER
DATE SIGNED
8/6/60

22e. BURIAL, CREMATION, REMOVAL (Specify)
Burial 22b. DATE THEREOF 8 August 1960 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glen Haven Cemetery
22d. LOCATION (City, town, or county) Glen Burnie, Md.

23. FUNERAL DIRECTOR
R. J. Singleton

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
DATE AUG 11 '60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

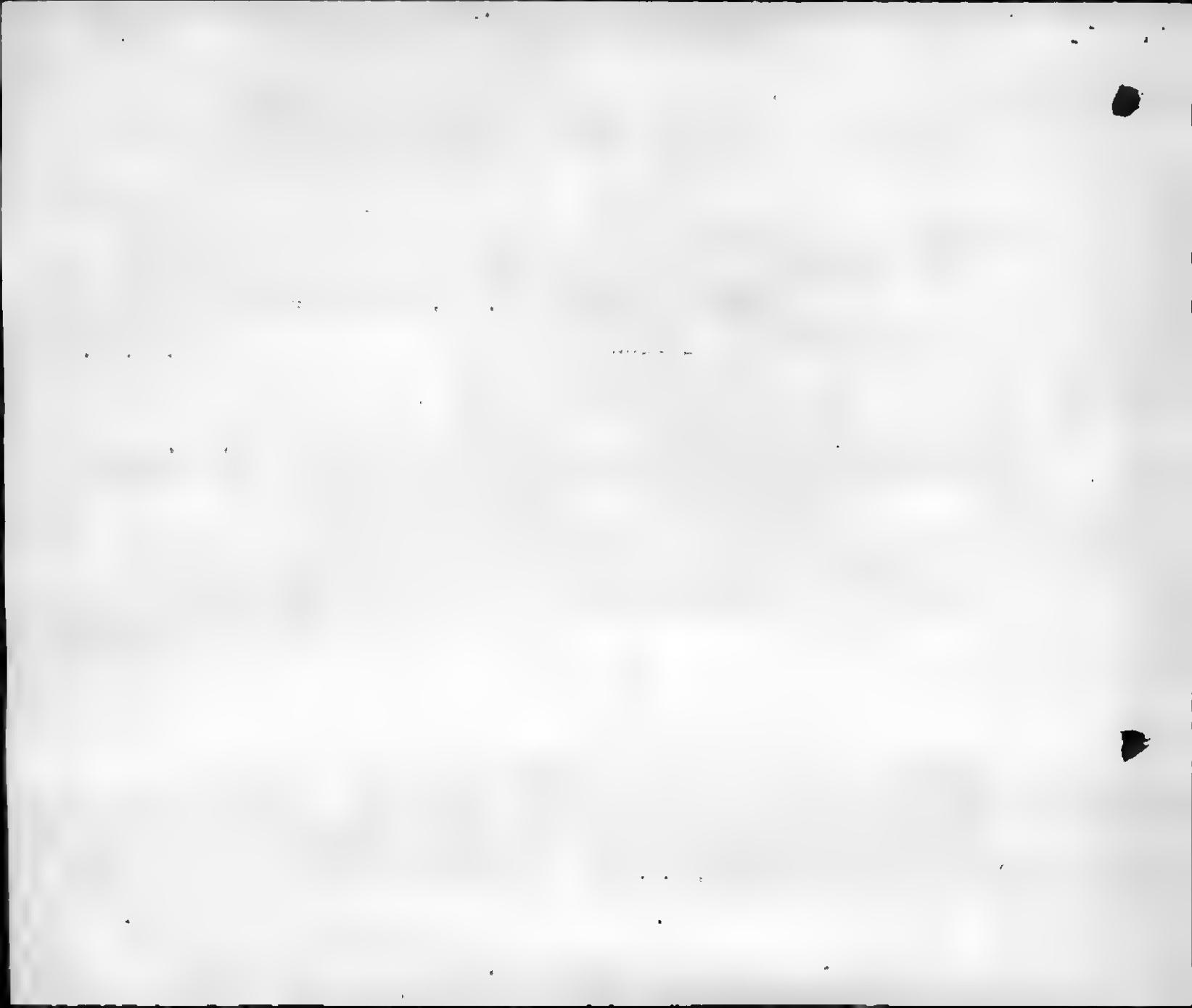
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08744

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		Lothian, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admis' on) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lothian				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Hugh	Middle Hugh	Last Rawlings	4. DATE OF DEATH	Month 8	Day 2	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1915 (44) 43 yrs.	9. AGE (In years by birthday) 43 yrs.	IF UNDER 1YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Anna A. Shepherd						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Ashby Shepherd - Lothian, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Fractured Neck						
712.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Multiple Contusions					
		DUE TO (c)	Probable Fractured Skull					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor overturned, pinned him under						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm	20f. (City or town) Lothian	(County) AA	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Emily H. Wilson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 8/2/60	
EXAMINER'S NAME (Type) Emily H. Wilson, M.D.								
22a. BURIAL, CREMATION, REMOVAL (specify) Burial	22b. DATE THEREOF 8/4/60	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery		22d. LOCATION (City, town, or county) Lothian		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home - Marlboro, Md.		ADDRESS Upper	24a. REC'D BY REGISTRAR Cathleen S. Francis		24b. REGISTRAR'S SIGNATURE Cathleen S. Francis			
		DATE AUG 9 '60						



Item 18 Film 269 6-1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8776

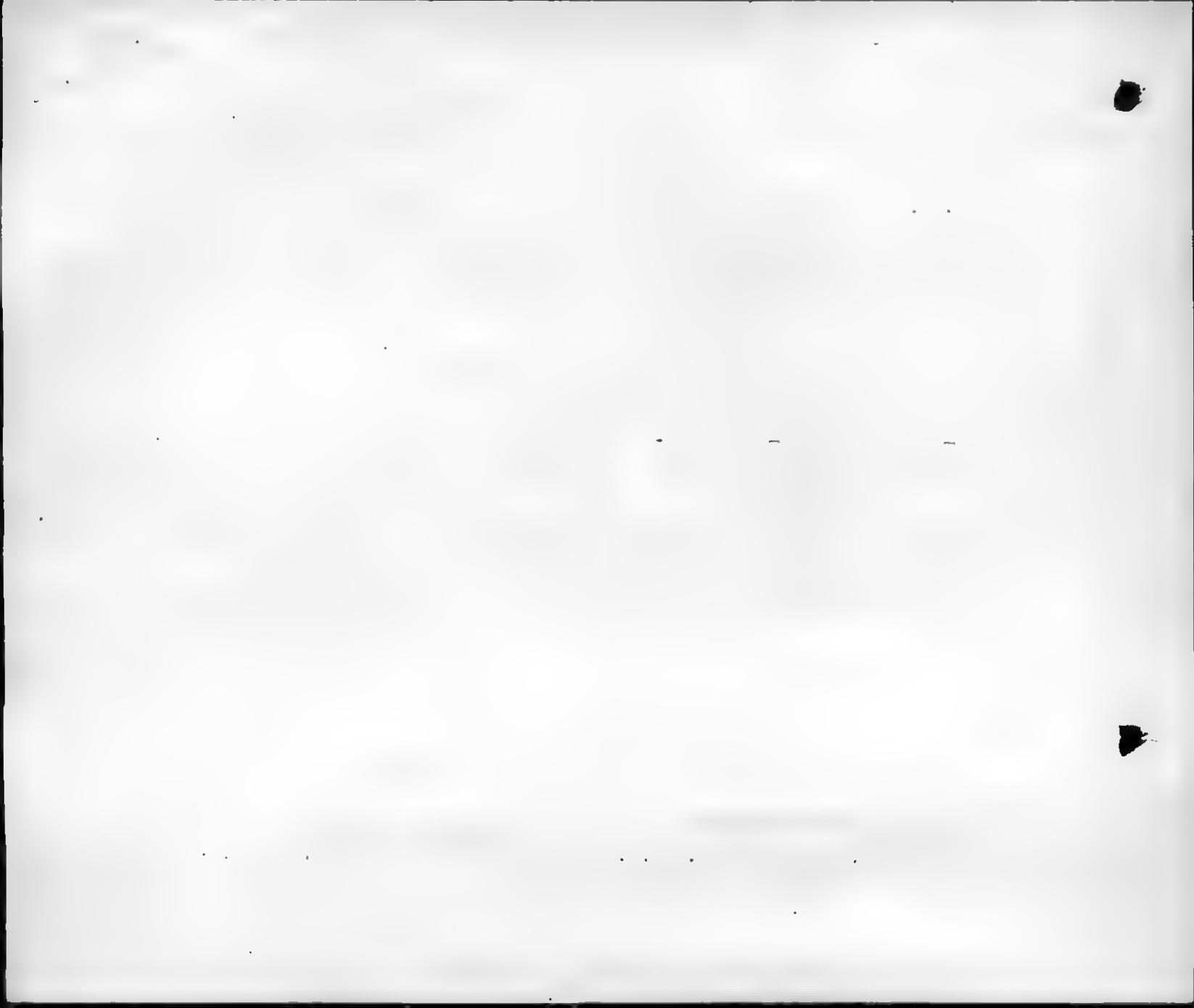
08745

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Geo G. Meade		c. LENGTH OF STAY IN lb Since 30 June 60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Torrence Middle W.		4. DATE DEATH Reeder Month August Day 2 Year 19 60	
S SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> N/A Divorced <input type="checkbox"/>	8. DATE OF BIRTH 30 June 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas L Reeder		14. MOTHER'S MAIDEN NAME Mary Wilhem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT (Father) Box 234 Rt # 2 Severna Pk, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 692.4 DUE TO Sepsis		INTERVAL BETWEEN ONSET AND DEATH Less than 24 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Abscess of leg & furuncle of arm. (c)			
PART II OTHERS MENTIONED CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 July 1960 to 2 August 1960, that (I) (we) last saw the deceased alive on 2 Aug 1960, and that death occurred at 5:25 PM from the causes and on the date stated above			
22a. SIGNATURE W.H. Miller Jr.		22b. DATE SIGNED 3 Aug 60	
22c. PHYSICIAN'S NAME (Last, First, Middle) WILBUR H. MILLER, Capt., M.C.		22d. ADDRESS USA Hosp Ft Geo G. Meade, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6 Aug. 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Baldwin's Memorial Ch. Cem.		23d. LOCATION (City, town, or county) Millersville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Singleton Funeral Home - Robert P. Ware		ADDRESS Glen Burnie	
		25a. REC'D BY REGISTRAR DATE AUG 12 '60	
		25b. REC'D BY REGISTRAR'S SIGNATURE Arthur S. Chase	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
or attending physician
or certifying has been signed by the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: All certificates should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 3/59
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1/1 2/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08746

Reg. Dist. No.

8777

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

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1. PLACE OF DEATH a. COUNTY <i>A. A. CO</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Margaret's RFD Annapolis</i>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3. NAME OF DECEASED (Type or print)</i>	
<i>VIRGILIA S. Riddle</i>		3. NAME OF DECEASED First <i>VIRGILIA</i> Middle <i>S.</i> Last <i>Riddle</i>	
4. SEX Female		5. COLOR OR RACE White	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Aug. 15, 1910</i>		9. AGE (in years last birthday) <i>50 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Norfolk, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles A. Saunders</i>		14. MOTHER'S MAIDEN NAME <i>Tinnie Cook</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <i>305 34 0106</i>	
17. INFORMANT <i>Thomas P. Riddle Jr.-Box 23 RFD 2</i>		Address <i>Arundel, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>(a), stroke the underlying</i> cause lost. DUE TO (c) <i>(a)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> or work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Riddle</i>		DATE SIGNED <i>5/16/60</i>	
EXAMINER'S NAME (Type) <i>E. L. Riddle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>Aug 20, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>		22d. LOCATION (City, town, or county) (State) <i>BALTIMORE, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Finnegan</i>		ADDRESS <i>Annapolis, Maryland</i>	
24a. REC'D BY REGISTRAR <i>Cathleen S. Flanagan</i>		24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Flanagan</i>	
DATE <i>AUG 18 '60</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

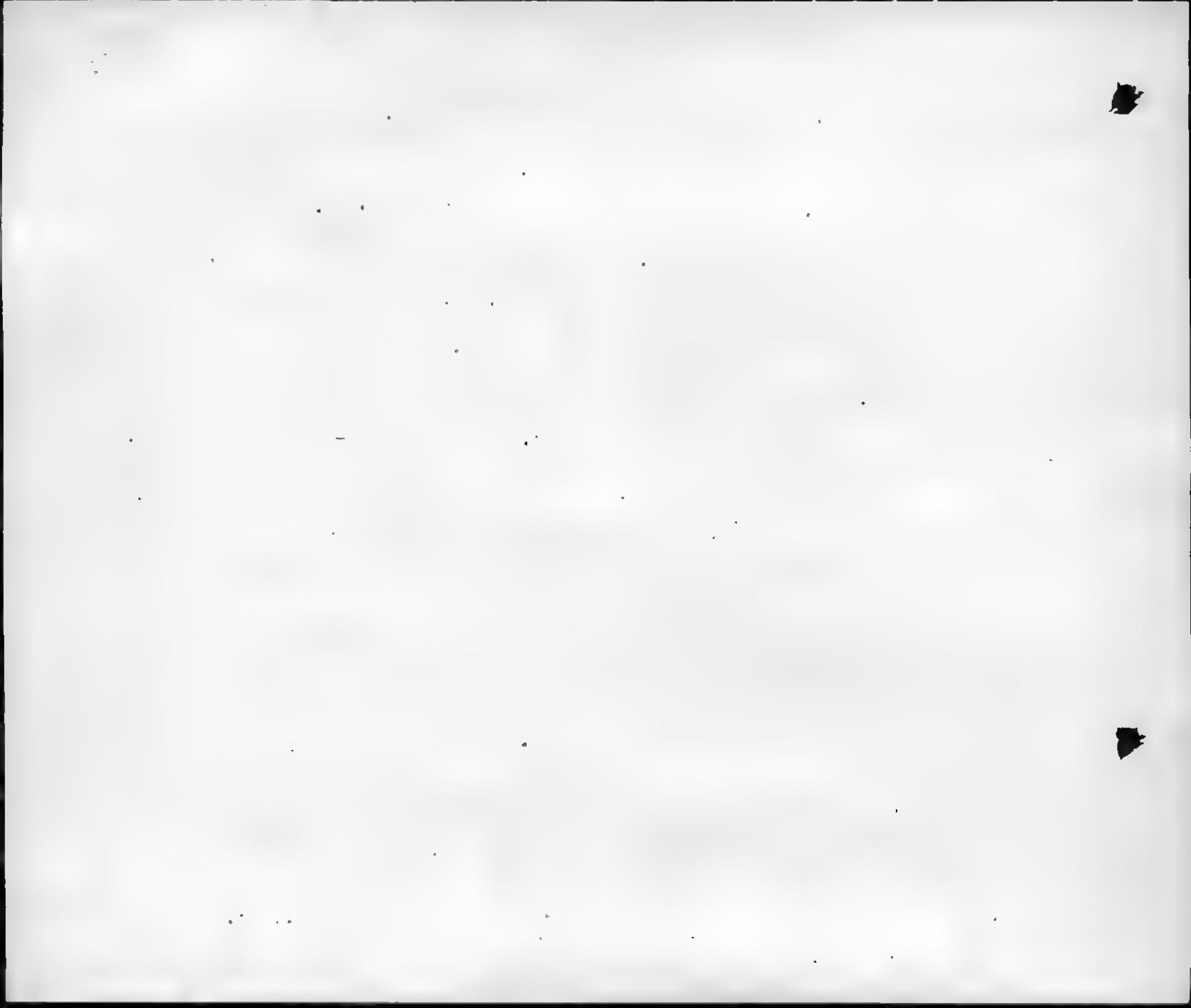
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8778

08747

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY A. A.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. LENGTH OF STAY IN 1b RURAL and give nearest town Ferndale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Chalmers Ave.		e. STREET ADDRESS 3619 Campfield Rd.	
3. NAME OF DECEASED (Type or print) ANNA		First E.	Middle ROBEY
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1885
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Percy Darnell		14. MOTHER'S MAIDEN NAME Mary Simons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Raymond Robey - 200 Chalmers Ave. Ferndale
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) DUE TO (c)		CRONARY THROM BOSIS CORONARY ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH IMMED 5 YRS	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-5 1960 to 8-6 1960. That (I) (we) last saw the deceased alive on 8-5 1960 and that death occurred at 10:30 AM, from the causes and on the date stated above.		22a. SIGNATURE Leon C. Perry,	
22c. PHYSICIAN'S NAME (Type) Burial		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS 201 BTA BLVD, GLEN BURNIE, MD.	22b. DATE SIGNED 8-8-60
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/9/60	23c. NAME OF CEMETERY OR CREMATORIUM Western Cem.	23d. LOCATION (City, town, or county) Balto. Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE John J. Schaefer & Sons - Balto. Md.	ADDRESS 17	25a. REC'D BY REGISTRAR DATE AUG 8 '60	25b. REGISTRAR'S SIGNATURE Walter S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 08748

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>3311 E. Pratt Street</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Johns Hopkins Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>John W. Rowssos</i>		First <i>J.</i>	Middle <i>W.</i>	Last <i>Rowssos</i>	4. DATE OF DEATH <i>April 25, 1895</i>	Month <i>5</i>	Day <i>1</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25, 1895</i>	9. AGE (In years less birthday) <i>65</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 MRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-09-1383</i>		17. INFORMANT <i>Mrs. Anna Rowssos, 3311 E. Pratt Street</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussive disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>								
4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO _____ (c) _____ DUE TO _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Saech</i>		DATE SIGNED <i>8/14/60</i>						
EXAMINER'S NAME (Type) <i>E. Saech</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-18-1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Meadowridge Memorial</i>		22d. LOCATION (City, town, or county) <i>Howard County, Maryland</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lilly & Zeiler Inc.</i>		ADDRESS <i>1901 Eastern Ave.</i>		24a. REC'D BY REGISTRAR <i>AUG 16 60</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Thorne</i>		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08749

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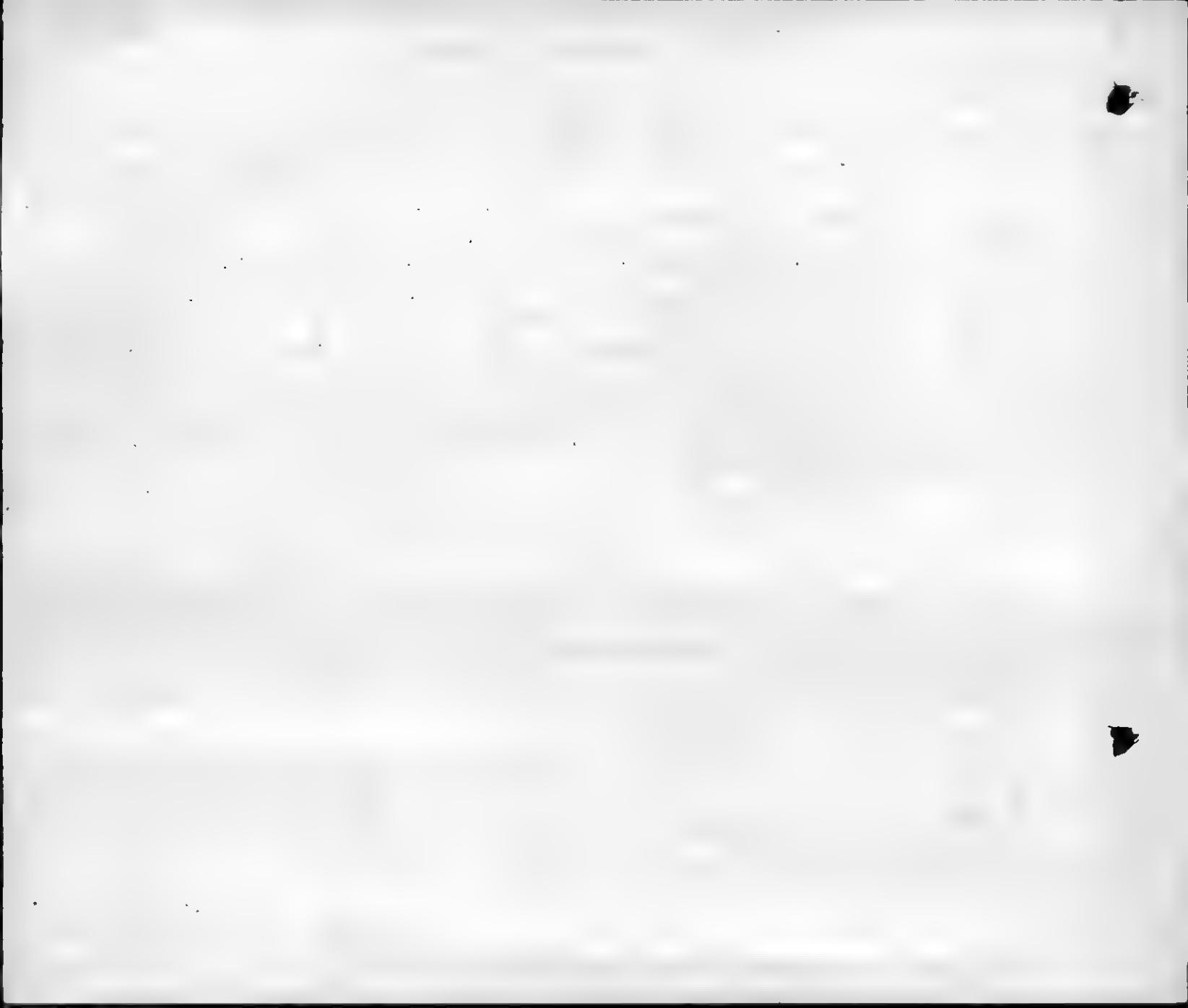
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Anne Arundel Maryland		Maryland Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Mercy Park-Glen Burnie 2 yrs		Mercy Park-Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		d. STREET ADDRESS #1 Beach Place	
3. NAME OF DECEASED (Type or print) Minnie G. Sanderson		4. DATE OF DEATH Aug 4 - 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2-1880-80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Talbot Co., Maryland
13. FATHER'S NAME C. J. Gambrill		14. MOTHER'S MAIDEN NAME (?) (P)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (216-07-5913D)	17. INFORMANT Mrs. Helen L. Ruff Raymond (Deceased)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Lobar Pneumonia & upper chest	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Arteriosclerosis - generalized Heart Failure	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1966, to Aug 4, 1966, that I last saw the deceased alive on Aug. 4, 1966, and that death occurred at 9:14 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Y.K. Yuan		ADDRESS (Street, city or town, state) M.D. 3818, S. Hanover St. Baltimore, Md.	
PHYSICIAN'S NAME (Type) Y.K. Yuan		DATE SIGNED Aug 5, 1966	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 8-1966		22b. DATE THEREOF May 22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cem. Brooklyn, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Evans		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. ADDRESS 400 S. Charles St.		REC'D BY REGISTRAR DATE AUG 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Mann	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, telephone call -Tickners-8/31/60. c.

08750

8736

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore (27)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1840		d. STREET ADDRESS 5512 Carville Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First BERTHA	Middle M.	Last SAPPINGTON	4. DATE OF DEATH Aug. 30, 1960	Month Aug.	Day 30,	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1898		9. AGE (in years last birthday) 62 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Schellor				14. MOTHER'S MAIDEN NAME Maria Elisa Hoenes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) →		16. SOCIAL SECURITY NO.		INFORMANT		Address		
				Dr. Robert Hahn - Severna Park, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. → DUE TO (b) DUE TO (c) DUE TO (d) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1954 , 19, to 1960 , 19, that I last saw the deceased alive on Sept 6, 19 , and that death occurred at 3 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Robert Hahn		ADDRESS (Street, city or town, state) Severna Park, Md.						
PHYSICIAN'S NAME (Type) Robert R. Hahn		DATE SIGNED 8/30/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/60		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tickner & Son - Balto		ADDRESS 177 Md		24a. REC'D BY REGISTRAR DATE AUG 31 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hahn		



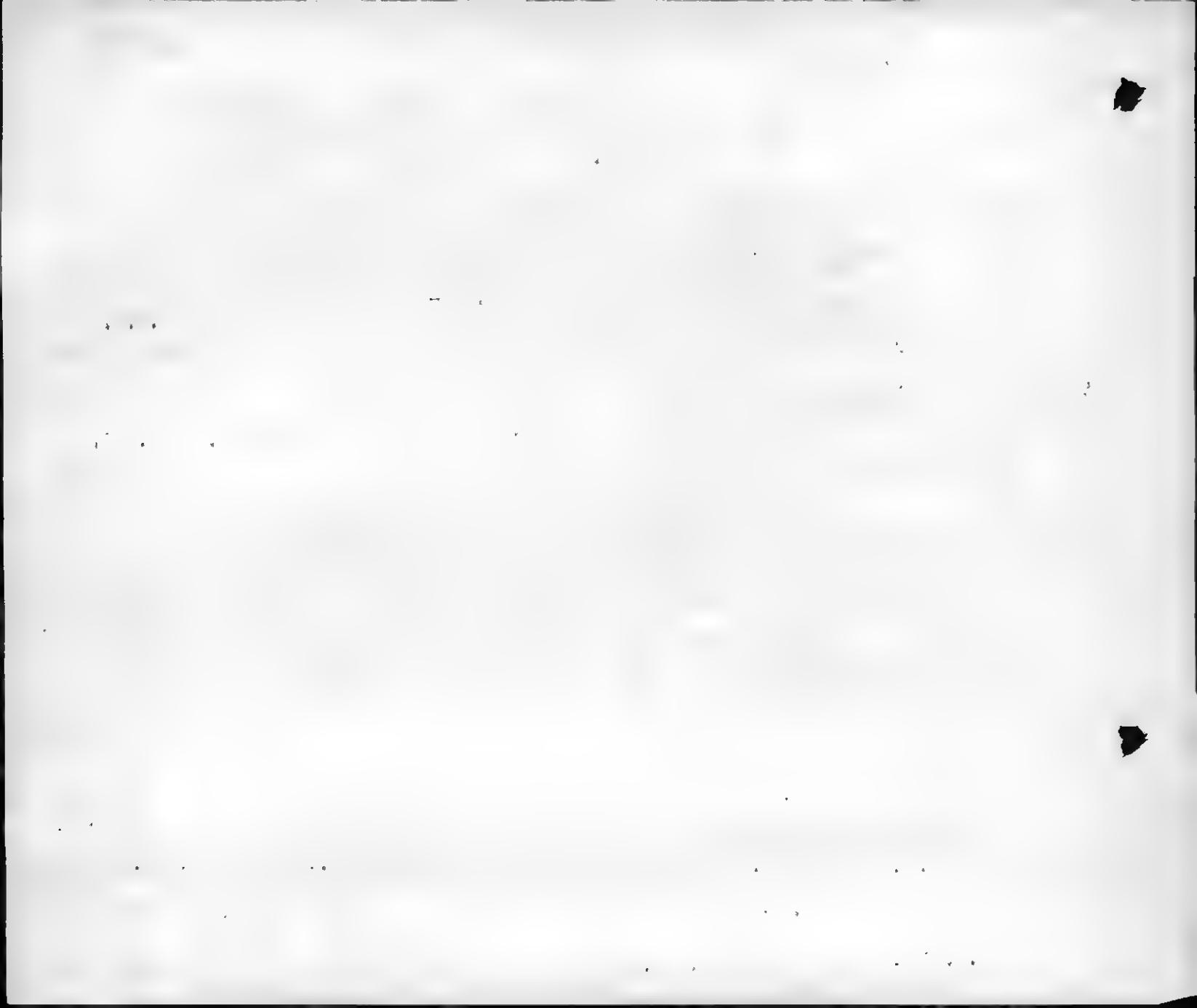
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08751

8726

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNT Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 Wks.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 32 Clay Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Jane		First	Middle	Last	4. DATE OF DEATH August 30
5. SEX Female		6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13-1876	Month Day Year Aug. 30 1960
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry		10b KIND OF BUSINESS OR INDUSTRY *****		11 BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Scales		14. MOTHER'S MAIDEN NAME Malinda Baker		12. CITIZENSHIP COUNTRY? Anne Arundel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO Un'nown		17. INFORMANT Charlotte Johnson - 32 Clay St. Annn. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last		CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH Today	
(b) DUE TO		HYPERTENSIVE CARDIO VASCULAR DISEASE		15 yrs.	
(c) DUE TO		NEPHRODYSIS & GEN. ALERGOSIS		10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/10/1960 to 8/30/1960 that (I) (we) last saw the deceased alive on 8/30/1960 and that death occurred on 8/30/1960, from the causes and on the date stated above					
22a. SIGNATURE Dr. Theodore H. Johnson		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) Dr. Theodore H. Johnson		22d. ADDRESS Calvert St., Annapolis, Md.			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 2-60		23c. NAME OF CEMETERY OR CREMATORIAL Brewer Hill	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Hicklin III		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE SEP 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

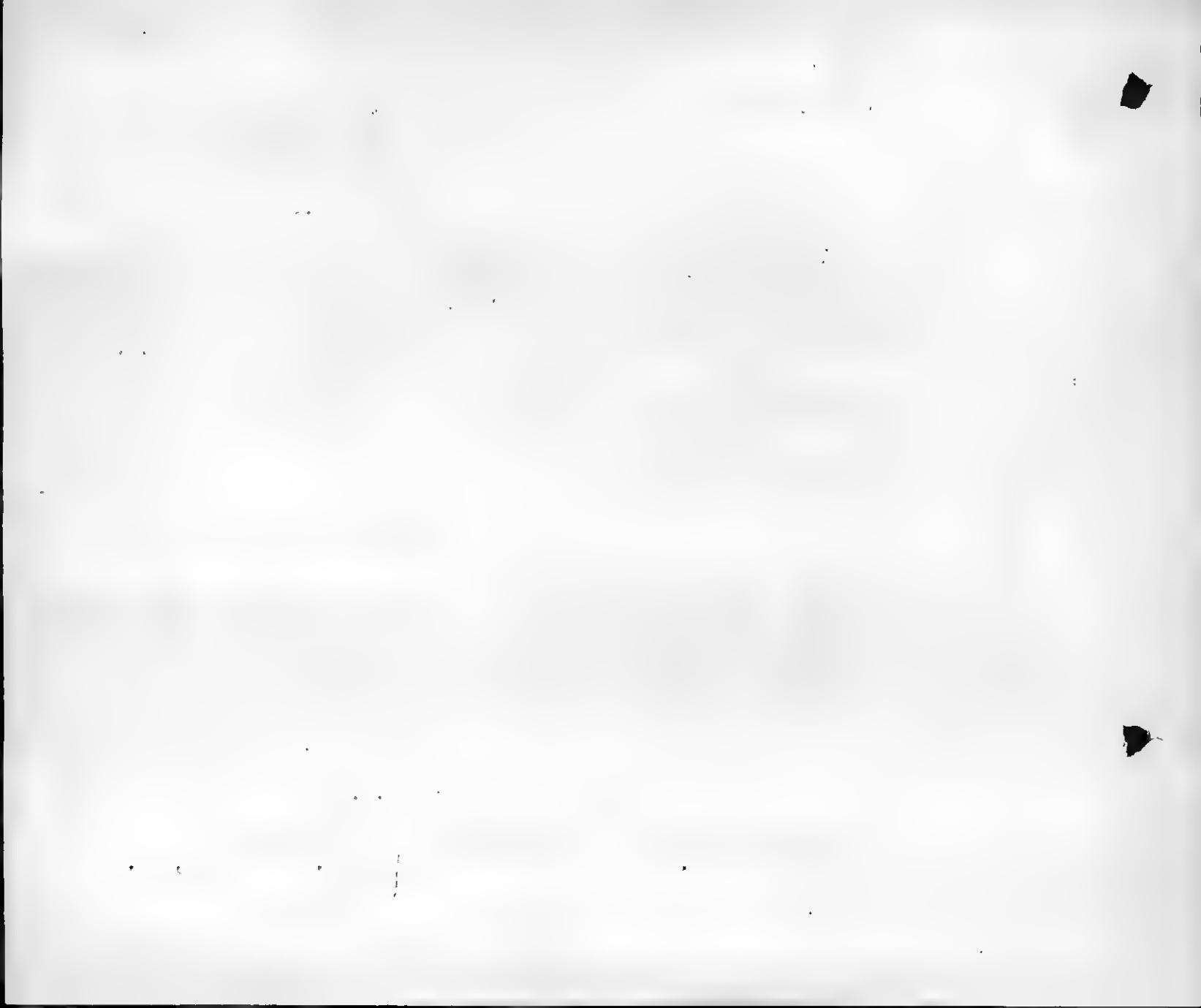
8727

08752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. STREET ADDRESS 1010 West St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Richard	Middle GREEN	Last SCIBLE
4. DATE OF DEATH	Month August	Day 2	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1885
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Lumber Business	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) 75 yrs	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John H. Scible	
14. MOTHER'S MAIDEN NAME Georgina Colinson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? Address (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Sarah L. Scible (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) inocard DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cessation of heart action DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —			
INTERVAL BETWEEN ONSET AND DEATH —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/5/60 to 11/21/60 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 8/24/60 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Edwin Davis, Jr.		22b. DATE SIGNED 8/2/60	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.		22d. ADDRESS 98 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 5 '60	
23c. NAME OF CEMETERY OR CREMATORIAL Hickory Memorial		23d. LOCATION (City, town, or county) Annapolis (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Son		25a. REC'D BY REGISTRAR DATE AUG 4 '60	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												08753											
8728				CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				b. COUNTY Montgomery															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 2 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 808 Sligo Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF (Type or print)		First John		Middle (N.M.)		Last SEDLMAIER		4. DATE OF DEATH		Month August		Day 9		Year 1960									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1900		9. AGE (In years last birthday) 60 yrs.		<small>IF UNDER 1 YEAR IF UNDER 24 HRS</small>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Paul Hetlick Co.				11. BIRTHPLACE (State or foreign country) Germany				12 CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME JOHN SEDLMAIER						14. MOTHER'S MAIDEN NAME ANNA ADELMANN																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO 212-14-5187				17. INFORMANT Mrs. Katherine L. Seldmaier, 808 Sligo Ave.				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]												<small>INTERVAL BETWEEN ONSET AND DEATH</small>											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous rupture of 456X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic aneurysm, crural (c) Intercostal haemorrhage																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardio - Vascular Disease												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)											
21. I certify that (I) (this hospital) attended the deceased from Aug. 7, 1960 to Aug. 9, 1960 , that (I) () last saw the deceased alive on Aug. 9, 1960 , and that death occurred at M. from the causes and on the date stated above.																							
22a. SIGNATURE Albert R. Anderson												M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/10/60			
22c. PHYSICIAN'S NAME (Type) A. L. Anderson												22d. ADDRESS 44 Southgate Ave., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) PITTS		23b. DATE THEREOF 8/13/60		23c. NAME OF CEMETERY OR CREMATORIAL PROSPECT HILL CEMETERY				23d. LOCATION (City, town, or county)		(State) WASHINGTON, D.C.													
24. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Pinsky, Inc.												ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR C. S. Turner		25b. REGISTRAR'S SIGNATURE C. S. Turner							



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08754

1. PLACE OF DEATH

a. COUNTY

A. Ado.

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Louise

5. SEX

6. COLOR OR RACE

Female

White

10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher Rtd

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY

Balto. County

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville, Maryland

0352-2

d. STREET ADDRESS

23 Somerset Road

West

4. DATE
OF
DEATH

Month

Day

Year

August,

18,

19 60

9. AGE (In years
last birthday)

66 yrs

IF UNDER 1 YEAR

Months

Days

Hours

Min.

11e. IS RESIDENCE
ON A FARM?

YES

NO

12. CITIZEN OF WHAT COUNTRY?

Md.

14. MOTHER'S MAIDEN NAME

Emma Jane Paynter

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Mr. Jos. B. Lambert - 342 E. University Pkwy.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

134-4

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Caediac Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 min

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

8/18/60

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

8/22/60

22c. NAME OF CEMETERY OR CREMATORIUM

Lorraine Park Cemetery

22d. LOCATION (City, town, or country)

Woodlawn Md.

(State)

23. FUNERAL DIRECTOR

John J. Piattner & Sons

Baltimore Md.

24a. REGISTRY REGISTER

AUG 29 1960

24b. REGISTRAR'S SIGNATURE

Arthur S. Evans

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

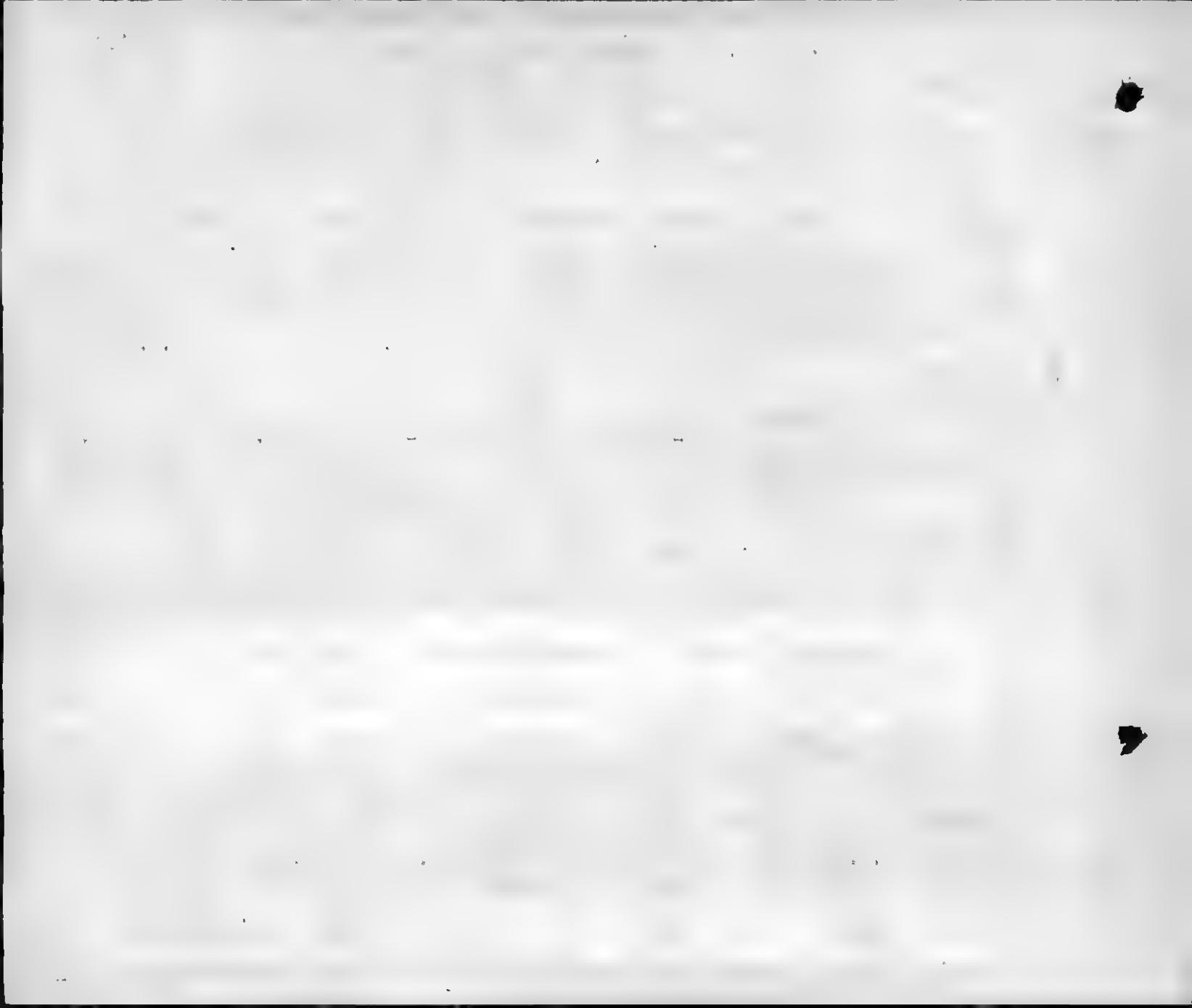
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8730

CERTIFICATE OF DEATH

08755
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b 40 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carver Street		d. STREET ADDRESS 3 Carver Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William	First McClain	Middle Sirurus	Last Month August 10 Year 1960
4. DATE OF DEATH	5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 22, 1905	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME McClain Simms	14. MOTHER'S MAIDEN NAME Georganna Howard	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-16-4503	17. INFORMANT Eleanor Simms - 3 Carver St. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. m.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 10 to 10, 1960, that I last saw the deceased alive on August 10, 1960, and that death occurred at 4:50 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) Clay st. Annapolis, Maryland DATE SIGNED ACTUAL SIGNATURE R. L. Richardson M.D.			
PHYSICIAN'S NAME (Type) R. L. Richardson	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF Aug 13, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Carver Hill	22d. LOCATION (City, town, or county) Annapolis, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE E. Hickey III	ADDRESS Annapolis, Maryland	24a. REC'D BY REGISTRAR Date AUG 16 '60	24b. REGISTRAR'S SIGNATURE Ollie S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8781

CERTIFICATE OF DEATH

Reg. Dkt No 8757

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WEEMS CREEK, ANNAPOLIS		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEMS CREEK	
d. STREET ADDRESS WEEMS CREEK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN HENRY	Middle SMITH	Last
4. DATE OF DEATH AUGUST 2 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Sept 27, 1874	8. AGE (in years lost birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired General Laborer		10b. KIND OF BUSINESS OR INDUSTRY US Gov.	10c. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William J. Smith	
14. MOTHER'S MAIDEN NAME Virginia Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT John W. Smith- Son- Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO <i>Arteriosclerotic C. V. Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957, 19 to Aug 2, 1960, that I last saw the deceased alive on August 2, 1960, and that death occurred at Annapolis, Maryland, from the causes and on the date stated above.			
ACTUAL AGE AT DEATH		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED 873/60	
MAURICE F. KLAWANS MD.		31 Southgate Ave. Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
H. S. K. Funeral Home		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Krause	

TO HOSPITAL OR ATTENDANT: I certify that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be rehanded by the hospital or attending physician and completely filled in by the funeral director. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

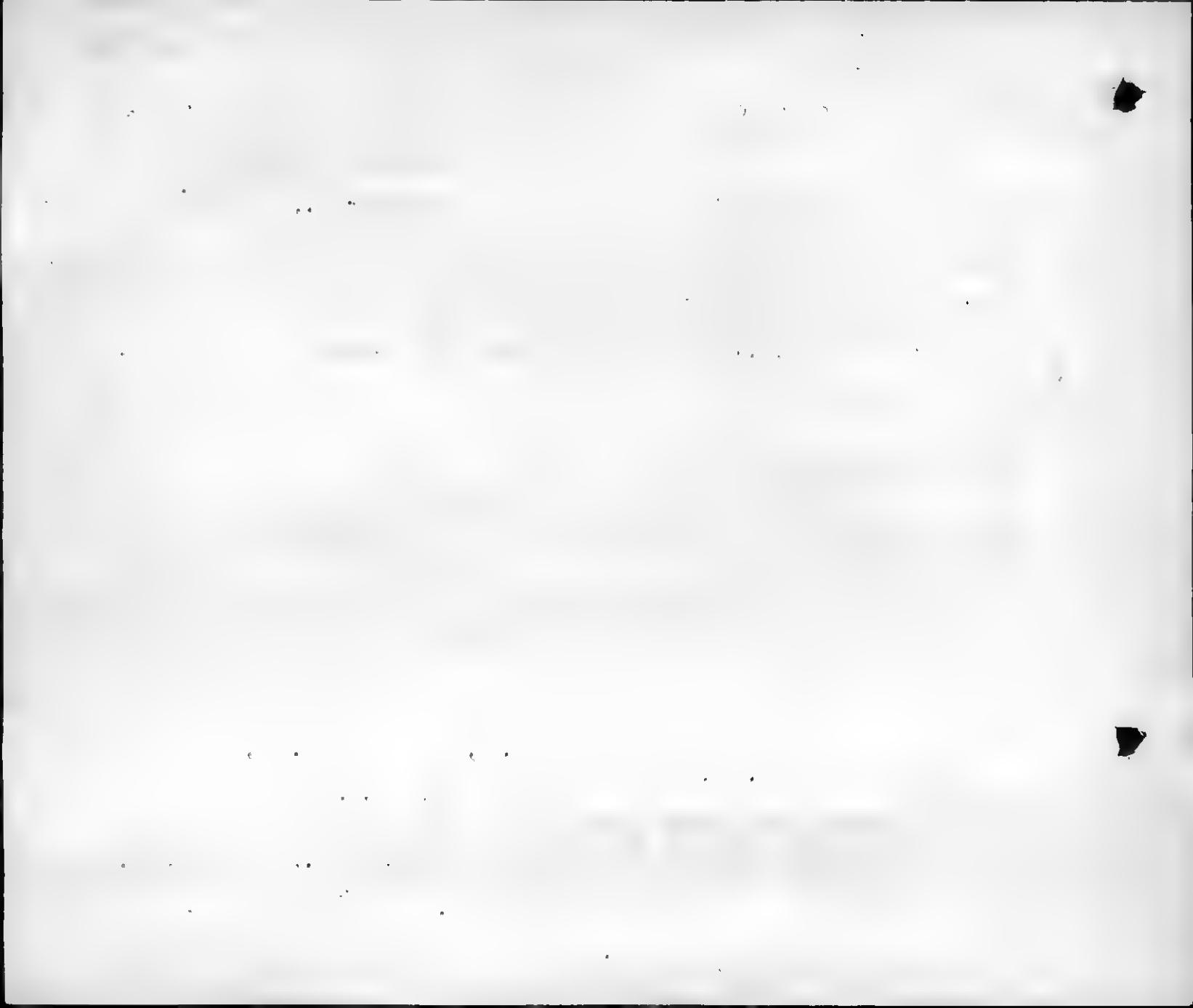
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8731

CERTIFICATE OF DEATH

08758

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3013 Weaver Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 3013 Weaver Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First Albert	Middle	Last	4. DATE OF STANEK	Month August	Day 30	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH April 23 1870	9. AGE (In years last birthday) 90 yrs	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		10b. KIND OF BUSINESS OR INDUSTRY U.S. Industrial Alcohol		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Stanek		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Frank Stanek, son, 3013 Weaver Avenue		Address Zone 14 Weaver Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C.V. Disease DUE TO (c) Fracture neck of L. femur							
INTERVAL BETWEEN ONSET AND DEATH 1 mmo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Fracture neck of L. femur							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING NO <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aug. 30, 1960					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, firm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) attended the deceased from Aug. 1, 1960, to Aug. 30, 1960, that (I) last saw the deceased alive on Aug. 30, 1960, and that death occurred at M. from the causes and on the date stated above.		12:40 P.M.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22a. SIGNATURE Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.					
22c. PHYSICIAN'S NAME (Type) Maurice Klawans							
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 9/3/60		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.		ADDRESS 2001 E. Madison St.		25a. REC'D BY REGISTRAR DATE SEP 2 '60		25b. REGISTRAR'S SIGNATURE Ciribus S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08759

8782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Md.</i>		b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>10 min.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>425 Ritchie Hwy Glen Burnie</i>		d. STREET ADDRESS <i>1 Herald Harbor Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>Allen</i>	Last <i>Stinchcomb</i>	4. DATE OF DEATH <i>August 3 1960</i>	Month Year	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Jan. 1, 1923</i>	9. AGE (in years last birthday) <i>37 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Roads</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Stinchcomb</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Moran</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>WW 11 48-14-2124</i>		17. INFORMANT <i>Leonard Stinchcomb, Crownsville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>		DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>(c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/3 1960</i> to <i>8/3 1960</i> , that I last saw the deceased alive on <i>8/3 1960</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Arundel Med. Grp., Glen Burnie, Md.</i> DATE SIGNED							
ACTUAL SIGNATURE <i>Ernest A. Leipold</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Ernest A. Leipold, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/6/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 5 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

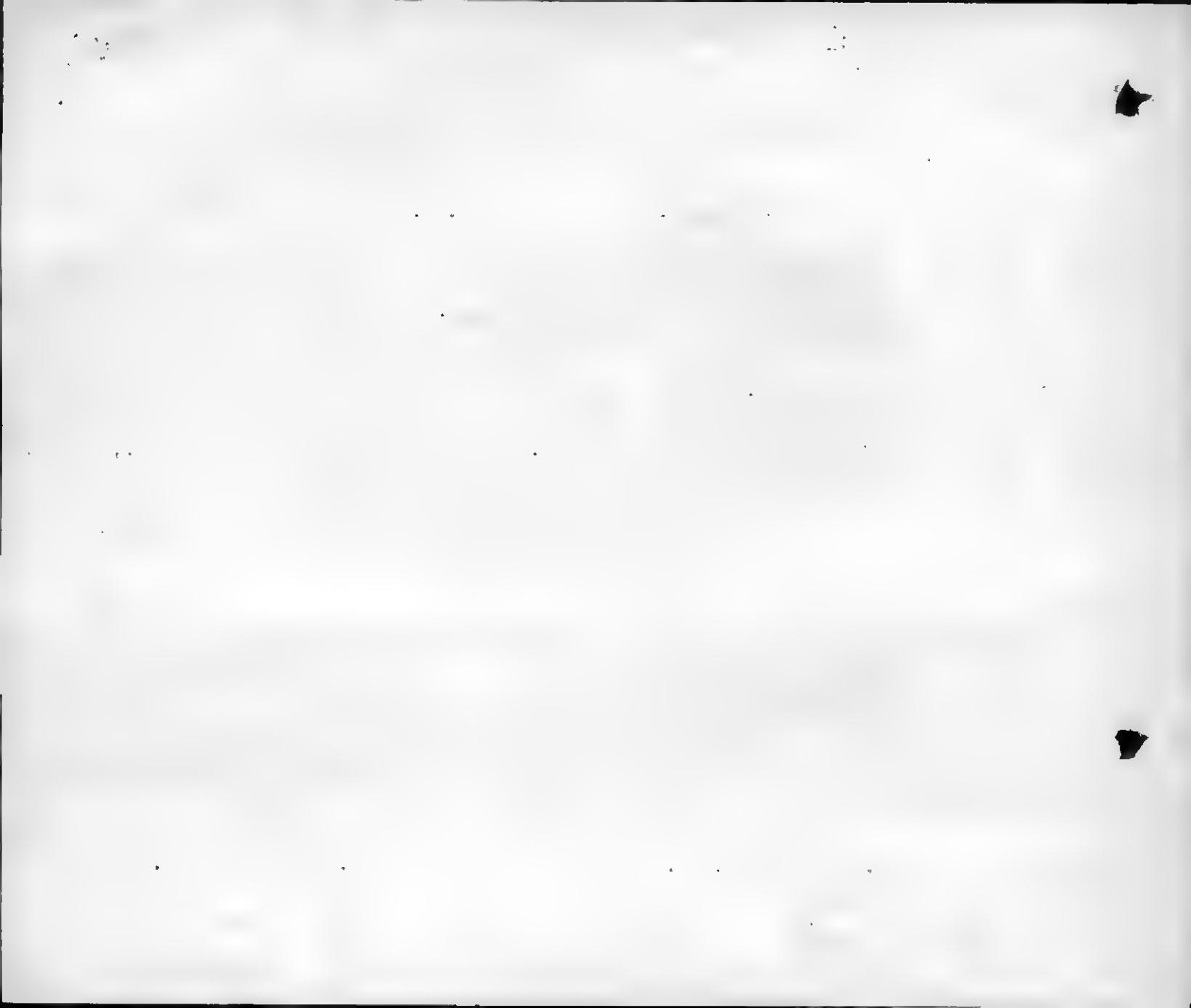
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8732

08760

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 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421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 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691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08761

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		II. 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
<i>ANNE ARUNDEL MARYLAND</i>		MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>ESSUP</i>			
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		<i>Baltimore City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION		d. STREET ADDRESS	
<i>MARYLAND House of CORRECTION</i>		<i>535 Wilson Court</i>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>RUDOLPH</i>		<i>W.</i>	<i>THOMAS</i>
4. DATE OF DEATH		Month	Day
		<i>AUGUST 22 1960</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>MALE</i>		<i>N</i>	<i>JULY 9, 1907</i>
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
		<i>53</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>LABORER</i>		<i>SIMPSONVILLE MD</i>	
11. BIRTHPLACE (State or Foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>SIMPSONVILLE MD</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>JAMES R. THOMAS</i>		<i>ADDIE GALLOWAY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.	
(If you have war or dates of service) <i>1995.</i>		17. INFORMANT	
		Address <i>MaryCommodore - 1542 Bruce St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Myocardiac Infarction	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		Coronary Thrombosis	
DUE TO <i>(c)</i>		46 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 7, 1960</i> to <i>Aug. 22, 1960</i> , that I last saw the deceased alive on <i>Aug. 22, 1960</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Baltimore, MD</i>	
ACTUAL SIGNATURE <i>Quinton L. L. C.</i>		DATE SIGNED <i>Aug. 25, 1960</i>	
PHYSICIAN'S NAME (Type) <i>Quinton L. L. C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 8/27/60</i>		22b. DATE THEREOF <i>8/27/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Auburn</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marshall P. Hayes 638 W. Baltimore St.</i>		24a. REC'D BY REGISTRAR DATE <i>Aug 25 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Callie L. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8784

CERTIFICATE OF DEATH

Reg. Dist. No. 08762.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u>		c. LENGTH OF STAY IN 16 <u>10 yrs.</u>	b. COUNTY <u>Anne Arundel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d STREET ADDRESS <u>Catherine St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3 NAME OF DECEASED (Type or print)	First <u>Herbert</u>	Middle <u>E</u>	Last <u>Tribett</u>	4. DATE OF DEATH <u>AUG. 30 1960</u>
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5 SEX <u>M</u>	6 COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 18 1878</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. Day <u>30</u>	13. Year <u>1960</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <u>Railroad conductor (ret.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>R&O</u>	11. BIRTHPLACE (State or foreign country) <u>Meiggs Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>George W. Tribett</u>	14. MOTHER'S MAIDEN NAME <u>unknown</u>	15. INFORMANT <u>Belter Tribett</u>	Address <u>Green Haven MD.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO <u>705-07-5765</u>	17. INFORMANT <u>Belter Tribett</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Gastric Carcinoma</u> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>6 MO.</u>
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)
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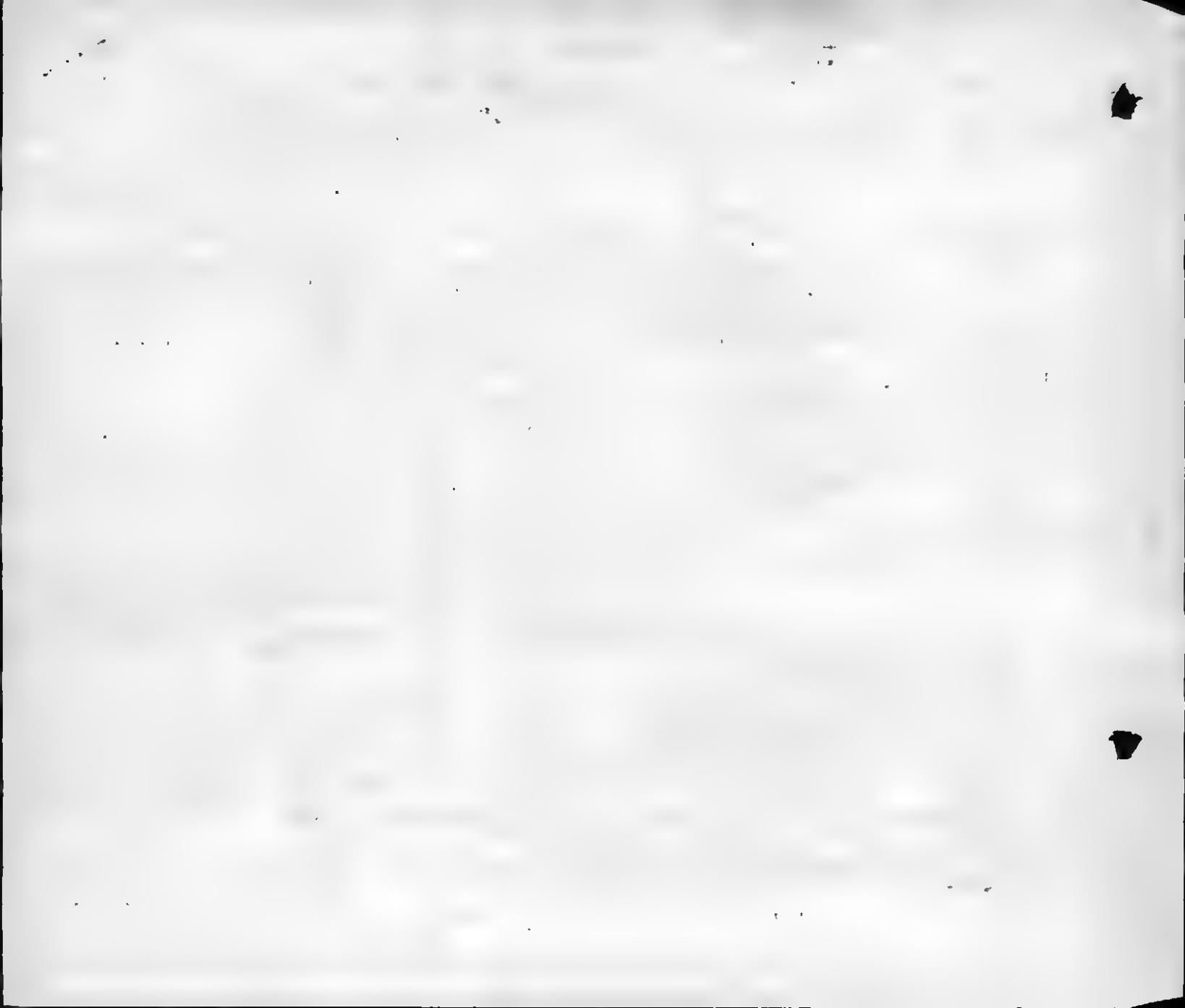
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>JAN 1956</u> , 19_____, to <u>AUG 1960</u> , 19_____, that I last saw the deceased alive on <u>AUG 29</u> , 19 <u>60</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <u>2934 MOUNTAIN RD.</u>	DATE SIGNED <u>8-30-60</u>
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ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>	M.D.	PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>	PASADENA, MD.
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sent. 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Northview Cemetery</u>	22d. LOCATION (City, town or county) <u>New Martinsville</u> (State) <u>W. Va.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>	ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08763 -

8785

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville, Md.</i>		c. LENGTH OF STAY IN 1b <i>38 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>maryland</i>		b. COUNTY <i>Anne Arundel Co</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brookwood Manor</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>		d. STREET ADDRESS <i>200 King Malcolm Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) <i>Clive Lipskey</i>		First <i>C</i>	Middle (Tucker) <i>T</i>	Last <i>lipskey</i>	4a. DATE OF DEATH <i>8/7/60</i>	Month <i>8</i>	Day <i>7</i>	Year <i>1960</i>	
S SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/22/1876</i>		9. AGE (in years last birthday) <i>83 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	12. IF UNDER 24 HRS Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if not retired) <i>Newspaper (est.)</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Cambridge, Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John R Morehead</i>			14. MOTHER'S MAIDEN NAME <i>Anne Morehead</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>Unknown</i>			17. INFORMANT <i>Lester P. Murphy</i>			Address <i>Millersville Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Cardio Vax Disease - Senility</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 Day 1 Year</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>An accident</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour <i>6</i>		Month <i>Aug</i>	Day <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Odenton</i>	20f. (City or town) <i>Odenton</i>	(County) <i>Columbus</i>	(State) <i>Ohio</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>6/29/60</i> to <i>8/7/60</i> , that (I) (we) last saw the deceased alive on <i>6/29/60</i> , and that death occurred at <i>Odenton</i> from the causes and on the date stated above									
22a. SIGNATURE <i>DR. JOSEPH LIPSKY</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <i>Odenton</i>						22b. DATE SIGNED <i>8/7/60</i>
22c. PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKY</i>		22d. ADDRESS <i>Odenton</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10 August 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>GreenLawn Cemetery Glen Burnie, Md.</i>		23d. LOCATION (City, town, or county) <i>Columbus, Ohio</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Washington</i>				25a. REC'D BY REGISTRAR <i>Aug 11 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Film 27 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8-66 ans 8733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08764

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Annapolis</i>			
c. LENGTH OF STAY IN 1b <i>401 Severn Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If patient in hospital, give street address) <i>401 Severn Ave</i>		d. STREET ADDRESS <i>401 Severn Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Linda</i>	Middle <i>Virginia</i>	Last <i>Warram</i>		
4. DATE OF DEATH	Month <i>8</i>	Day <i>17</i>	Year <i>1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Sept 17 1958</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Leonard W. Warram</i>	14. MOTHER'S MAIDEN NAME <i>Gonko Koshinaka</i>	Address <i>2220</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>- - - - -</i>	17. INFORMANT <i>Leonard W. Warram</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Septicemia</i> (c) <i>Septicemia</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Injection of Klonopin with aspiration of vomitus</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Injection of Klonopin with aspiration of vomitus</i>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Annapolis</i>	(County) <i>Annapolis</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Elinhardt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <i>8/17/60</i>	
NAME (Type) <i>Elinhardt</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-19-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>National Cemetery</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>	ADDRESS <i>1001 M. Taylor, Inc. Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>Cathleen S. Turner</i>	24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Turner</i>	DATE AUG 22 '60	
VS. A15ME(S) SM 9/55					

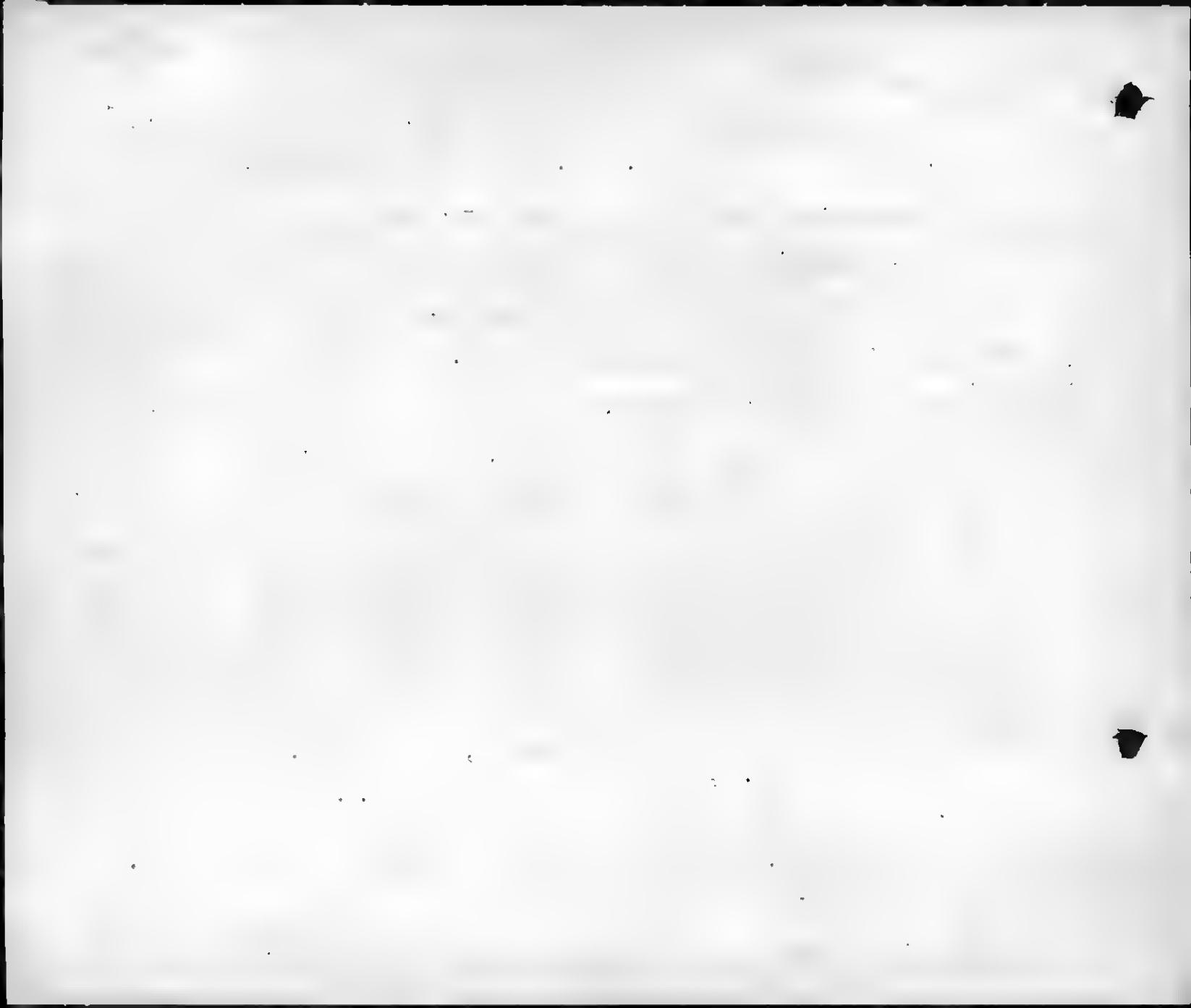


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										8734	08765	
CERTIFICATE OF DEATH										Item 16 #31647-9-20-60-01		
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
Anne Arundel			a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			b. COUNTY Anne Arundel									
c. LENGTH OF STAY IN 1b 2 mos. 5 da.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater,									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital			d. STREET ADDRESS Cape Loch Haven, Rt-3, Box-880									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
REUBEN Rubin		L	WASTLER	August	5	19	60					
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.			
Male	White			October 1, 1902	57 yrs							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). MAINTENANCE MAN			10b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING			11. BIRTHPLACE (State or foreign country) BALTO. MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME Newton S. Wastler Molly Hieberder											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address									
	214-03-4397	Mrs. Rose E. Wastler #2										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										Carcinoma of pancreas. 3 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 31, 1960, to Aug. 5, 1960, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Aug. 5, 1960, and that death occurred at M, from the causes and on the date stated above.			6:00 P.M.									
22a. SIGNATURE Richard N. Peeler			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/9/60							
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler			22d. ADDRESS 121 Cathedral St., Annapolis, Md.									
23a. BURIAL, Cremation REMOVAL (Specify)		23b. DATE THEREOF Aug 9th 1960		23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST MEY		23d. LOCATION (City, town, or county) ANNAPOLIS MD			(State)			
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR & SONS ANNAPOULIS MD		ADDRESS		25a. REC'D BY REGISTRAR DAUG 10 '60		25b. REGISTRAR'S SIGNATURE Charles E. Tamm						



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8786

CERTIFICATE OF DEATH

Reg. Dist. 08766

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Yo		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Selly on the Bay		X		Selly on the Bay		Rt 1 Box 253 Edgewater Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. DATE OF DEATH		Month		Day	
Selly on the Bay		d. STREET ADDRESS		Aug. 25		Year		1960	
3. NAME OF (Type or print) Elizabeth		First	Middle	Lost	4. DATE OF DEATH	Month		Day	
Female White		WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	1 - 3 - 1907	5. SEX	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Months		Days	
Housewife		Home		Maryland		Hours		Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		3 yrs.		U.S.A.	
William Waltman		Elizabeth King		Address		2			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH			
(If yes, give war or date of service)		-		Catherine Weed		3 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute pneumonitis & cardiac failure		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		3 years.	
		DUE TO		Arteriosclerotic hypertensive cardio- vascular disease and		DUE TO		2 years.	
		(b)		brain tumor		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town)		(County) (State)	
Month, Day, Year Hour p.m.		19							
21. I certify that I attended the deceased from Aug. 1, 1959, to Aug. 25, 1960, that I last saw the deceased alive on Aug. 25, 1960, and that death occurred at 6:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED					
MEDICAL CERTIFICATION		Signature		R.H.D.H. Box 277-M		8/26/60			
PHYSICIAN'S NAME (Type)		Sylvia M. King M.D.		Edgewater, Md.					
22e. BURIAL, CREMATION, REMOVAL (Specify)		22f. DATE THEREOF		22g. NAME OF CEMETERY OR CREMATORIUM		22h. LOCATION (City, town, or county)		(State)	
Burial Aug 29-1960		St. Stephen's Church		Mt. Bradford		Md			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
John M. Taylor Sons Undertakers Md		ADDRESS		DATE AUG 30 '60		Charles J. Hunt			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 7 Film G269 8-29-60 et

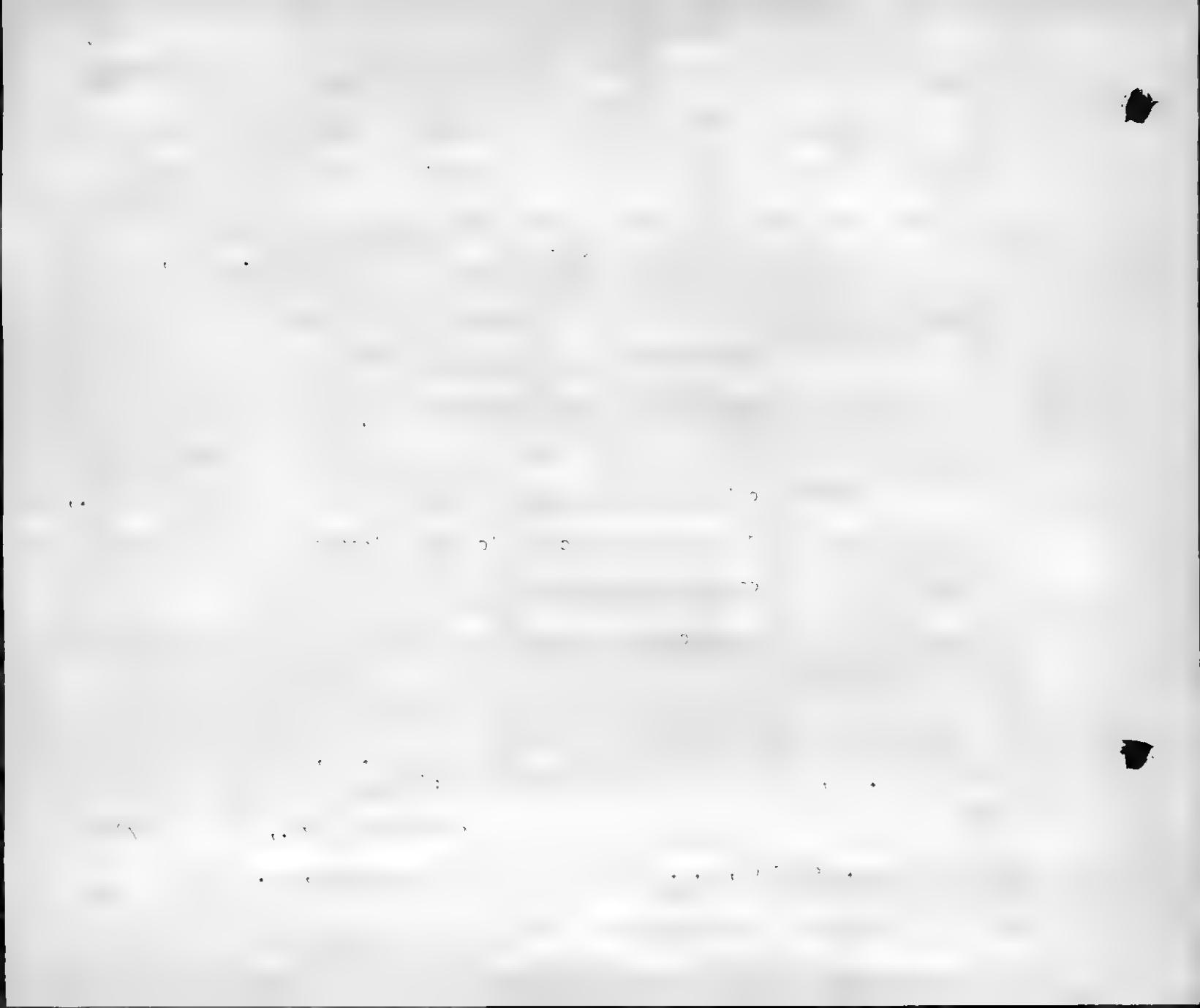
08767

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md. Stateville Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Halesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Halesville			
d. LENGTH OF STAY IN lb		71		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
William F				Woodfield	Aug.	19,		1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 23, 1888	71 yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Woodfield Fish & Oysters Co. Seafood				Halesville		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
William C Woodfield		Ida W. Seigert							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						Nina E. Woodfield			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema						4 hrs..			
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary atherosclerotic heart disease				1950			
DUE TO									
		(c) coronary thrombosis				1955			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that I attended the deceased from 1941, 19, to Aug. 19, 1960, that I last saw the deceased alive on Aug. 18, 1960, and that death occurred at 9:57 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
						DATE SIGNED			
ACTUAL SIGNATURE		<i>S. Borssuck</i>		M.D.		Amos Garrett Blvd., 8/22/60			
PHYSICIAN'S NAME (Type)		S. Borssuck, M.D.				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial		Aug. 23, 1960		Casket		Halesville		Tid.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
				DATE AUG 25 '60		<i>Linda S. Thorne</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

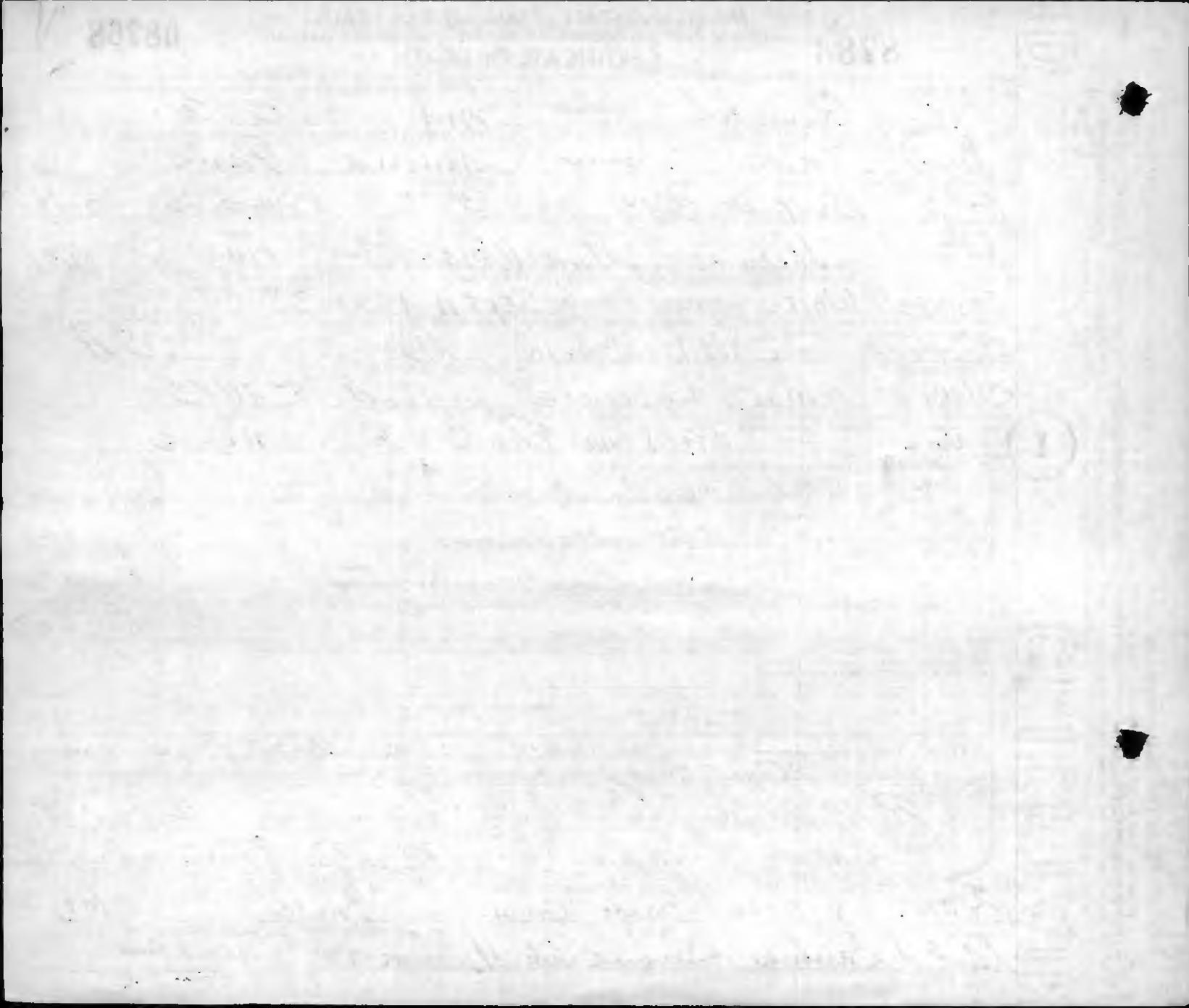
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08768

8788

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>	c. LENGTH OF STAY IN 1b <i>3 years</i>	b. COUNTY <i>A. A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rt 2 Box # 383</i>	e. STREET ADDRESS <i>Rt 2 Box # 261</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thelma Mae Wright</i>	First <i>Thelma</i>	Middle <i>Mae</i>	Last <i>Wright</i>
4. DATE OF DEATH <i>Aug 8 1960</i>	Month <i>Aug</i>	Day <i>8</i>	Year <i>1960</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 16 1921</i>
9. AGE (In years last birthday) <i>38 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DEFENSE work</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>G. I. MARTIN MD.</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>CHARLES HOWARD LINDEMORE</i>	14. MOTHER'S MAIDEN NAME <i>Lillian BANKS</i>	Address <i>ABOVE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>29-18-411</i>	17. INFORMANT <i>FAMILY</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>010X</i>		cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH <i>30 mins.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH <i>1 year.</i>	
DUE TO (c) DUE TO Tuberculous meningitis INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Aug 8 1960</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) attended the deceased from <i>Aug 15 1958</i> to <i>Aug 8 1960</i> , that (I) last saw the deceased alive on <i>Aug 8 1960</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.		22b. DATE <i>Aug. 8, 1960</i>	
22a. SIGNATURE <i>R. M. McLaughlin</i>		22b. DATE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		22d. ADDRESS <i>3708 Mountain Rd. Pasadena Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-11-60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Balto. GEM.</i>		23d. LOCATION (City, town, or county) <i>Balto.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Barnes</i>		ADDRESS <i>Severna Park, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>AUG 12 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8789

CERTIFICATE OF DEATH

Reg. Dist. No.

08769

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9mo. 4 years 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1122 N. Fulton Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph		First	Middle	Last	4. DATE OF DEATH Young	Month 8	Day 9	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 5, 1893	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Franklin Young				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral Hypostatic Pneumonia						
4-22.1 Causes, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		Arteriosclerotic Cardiovascular Disease						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome Associated with Meningo-Vascular Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Hour o. m. --- - 19 p. m. --- -	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----		
21. I certify that I attended the deceased from _____ 11/8, 19 55, to 8/9, 19 60, that I last saw the deceased alive on 8/9, 19 60, and that death occurred at 3:30A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED						
ACTUAL SIGNATURE <i>L. Benedict, M.D.</i>	M.D. Crownsville State Hospital, Md. 8/9/60							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.	Crownsville State Hospital, Md. 8/9/60							
22a. BURIAL/CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/10/60	22c. NAME OF CEMETERY OR CREMATORIAL <i>City of Maryland</i>	22d. LOCATION (City, town, or county) <i>Baltimore City</i>	(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Reutter</i>	ADDRESS <i>108 W. Wash. St.</i>	24a. REC'D BY REGISTRAR DATE AUG 18 '60	24b. REGISTRAR'S SIGNATURE <i>John J. Keenan</i>					

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